

WI 332

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

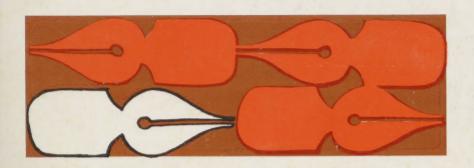
Michigan Medicine

VOLUME 68

RECEIVED

OCT 2 4 1969

National Library
of Medicine



AMONG THE EXCELLENT ARTICLES IN THIS ISSUE:

The Story of Detroit's Cholera Epidemics of 1832 and 1834

A Research Protocol Review Committee for the State of Michigan

Michigan Launches Rubella Immunization Campaign

The Michigan State Medical Society Meets the John Birch Society

Michigan Students to Have Superior Health Education



TO READ OVER A GOOD CUP OF COFFEE:

Detroit Doctor's Book on Government Reviewed

Medicare-Medicaid Questions Answered

Latest Developments on Governmental-Medical Care Programs

Michigan Health Council Recommends Cigaret Tax Boost



MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

OCTOBER 1969 • VOLUME 68 • NUMBER 19

TABLE OF CONTENTS ON PAGE 1009

Governor Proclaims Health Week; Physicians Invited to Two Special Meetings

In the presence of a distinguished audience of the state's health leaders, Gov. William Milliken on Sept. 23 proclaimed the week of Oct. 19-25 as Community Health Week in Michigan.

Putting his name to the statement, he officially aided the special project of the Michigan State Medical Society, Michigan Health Council and Michigan Association of the Professions with emphasis this year on attracting Michigan's youth to health careers.

The week of activities in October will include a kickoff Monday, Oct. 20, at the University of Michigan, featuring an appearance by Gov. Milliken, and an all-day program Thursday, Oct. 23, to provide the opportunity for over 100 high school guidance counselors to meet and plan programs with state health professionals.

A poster contest among the state's youth will be conducted throughout the week, as well as numerous local televised, broadcast and printed interviews with state health leaders.

The proclamation reads:

WHEREAS, good health is the most priceless possession of every man, woman and child in our state, and

WHEREAS, good health is one of the state's most valuable resources and one vital to the safety, growth, productivity and progress of our state and each individual in it, and

WHEREAS, maintaining or improving public health and a high-level of individual dynamic fitness is a constant, high-priority goal of the state, and

WHEREAS, the many members of the community health team, by working together and with continued public support, have made immense strides in protecting and improving public health and assuring that health care services are available to all, and

WHEREAS, medicine's endless quest for new discoveries and methods to make life freer from serious disease and to rehabilitate the ill and injured is reaching toward even greater heights, and

WHEREAS, emphasis on health care services is so predominant today that the health care services field is well on its way toward becoming the nation's largest single civilian employment field, and

WHEREAS, one of every 10 high school graduates must be attracted every year for years to come into medicine and its allied fields to meet growing demands in providing health care services, and

WHEREAS, we must strive to encourage each of our communities to have the vision and the essential, continued coordinated teamwork and planning necessary to meet and cope with tomorrow's health needs so that the highest level of health protection and total health care services will be available to all:

NOW THEREFORE, I, William G. Milliken, Governor of the State of Michigan, do hereby proclaim the week of Oct. 19-25, 1969, as Community Health Week throughout the State of Michigan and call upon the Michigan State Medical Society, county medical societies, state and county health departments, allied health professions, public and private health organizations and agencies, civic organizations and public schools to join in its observance to demonstrate to the people of Michigan how they're teaming up for better health and to increase public awareness of the many health facilities and services available at the community level to enrich the lives of all of us and those who will follow us.

Southwestern Michigan Clinic Day Oct. 30

The annual Southwestern Michigan Clinic Day, sponsored by the Calhoun County Medical Society, is scheduled all day Oct. 30 at the Battle Creek Country Club.

Seven distinguished physicians from Michigan and out-of-state will discuss a variety of subjects. The annual Russell L. Mustard Memorial Lecture will be delivered by Edgar Kahn, M.D., professor of neurosurgery at the University of Michigan. His topic will be "Some Unusual Neurosurgical Lesions."

The Clinic Day, which begins at 9 a.m., will also present talks by Kenneth Magee, M.D., professor of neurology at the University of Michigan, who will discuss "Parkinsonism;" William Robinson, M.D., professor of internal medicine at the U-M, whose topic will be "Joint Diseases;" Joseph Posch, M.D., Detroit hand surgeon, whose topic will be "Hand Infections."

Out-of-state speakers will be Mark Ravitch, M.D., professor of pediatric surgery at the University of Chicago; Henry Bahnson, M.D., professor of cardiac surgery at the University of Pittsburgh, and Cyrus Blanchard, M.D., professor of otolaryngology at the University of Maryland, who will discuss "Dizziness."

Following the lectures will be round table discussions involving the speakers, with ample time for questions and comments, according to John B. Huntington, M.D., chairman of the clinic day committee. Also scheduled is a noon luncheon.

Interested MSMS members in southwestern Michigan are invited. Programs are available from Doctor Huntington at 710 North Ave., Battle Creek 49017.

MSMS Public Relations Idea Applauded By AMA Officials

AMA officials are applauding the MSMS Public Relations Committee and the MSMS Council for urging the officers of the county medical societies "to confer at least once a year with the presidents of other local community organizations."

"Your recent memorandum to county medical society presidents regarding their involvement in community activities makes a lot of sense," wrote Charles S. Lauer, director of the AMA Communications Division.

The MSMS letter and proposed county society activities, wrote D. W. Power, Director of the AMA Department of Field Service, "looks like an excellent approach to solving a long-standing problem of an effective liaison with important groups in the community."

The idea that county society officers confer with the leaders of other community groups about common concerns was recommended to the Council by the MSMS Public Relations Committee at its last meeting held by Brock E. Brush, M.D., PR chairman.

R D ALERT SCHEDULED SEPT. - OCT.

According to Winthrop N. Davey, M.D., president of the Michigan Tuberculosis and Respiratory Disease Association, state Christmas Seal agency, a state-wide Respiratory Disease Alert will be conducted during the months of September and October in Michigan.

During September thoracic surgeons, internists, allergists, doctors in general practice and other physicians who work primarily with respiratory diseases will receive a special mailing containing a copy of a physicians' publication obstructive Pulmonary Disease — A Manual for Physicians," as well as a copy of a publication designed for patients with a respiratory disease problem, "What You Can Do About Your Breathing."

In addition an order form with a listing of RD publications will be enclosed for additional orders. County TB and RD Associations will also conduct similar mailings. Physicians will be encouraged to participate in the RD Alert.

NATIONAL PHARMACY WEEK OCT. 5-11

"Drug Abuse . . . Escape to Nowhere" is the theme of the 45th annual observance of National Pharmacy Week which has been scheduled for Oct. 5-11.

HEW officials estimated recently that five to seven million persons in the U.S. have used marijuana at least once. Other HEW drug abuse statistics indicate that the abuse of chemicals has increased dramatically in the country.

Special efforts during Pharmacy Week will be made to alert the public to the problem of drug abuse.

Oakland Auxiliary Raises Funds For Nurse Scholarships

The Woman's Auxiliary to the Oakland County Medical Society will raise monies for its Nurse Scholarship Fund by sponsoring a weekend in New York Nov. 6-9 for its members and their husbands. The weekend package price will include round-trip air fare, accommodations, a Broadway play, dinner and show, transfers, tips and tour escort.

MAP Elects New Officers For New Year

The Michigan Association of the Professions (MAP) has a new slate of officers and directors.

They include Charles H. King, J.D., Detroit, president; Chauncey A. Norton, C.P.A., Detroit, vice president; Harold D. Sheridan, D.V.M., Coopersville, secretary; Douglas M. Ammons, R.Ph., Lansing, treasurer. Hugh Brenneman and Mrs. Helen Brenneman, East Lansing, continue as executive director and associate executive director, respectively.

New members of the MAP board of directors are John W. Cummiskey, J.D., Grand Rapids; Richard L. Dorner, D.V.M., Kalamazoo; Terry Herndon, M.A., East Lansing; Albert B. Shulman, D.D.S., Southfield; George W. Slagle, M.D., Battle Creek; Alfred D. Teetzel, C.P.A., Detroit, and Douglas Ward, M.A., Mt. Clemens.

Doctor Barnard To Address Nat'l Med. Assistants

Members of the Michigan State Medical Assistants Society who travel to Honolulu, Hawaii, Oct. 15-19 for the 13th annual convention of the American Association of Medical Assistants, will hear Christiaan N. Barnard, M.D., South Africa, world-famous heart surgeon, who will be the featured speaker. Other notables to appear on the program are Gerald D. Dorman, M.D., AMA president, and George H. Mills, M.D., president of the Hawaii Medical Association.

DETROIT COMPUTER FIRM BOUGHT

The Computer Control Corporation of Detroit has been purchased by the Remote Computing Corporation, a California-based computer utility that specializes in industrial and commercial timesharing services. Among services the Detroit firm has provided since its formation over two years ago was one of hospital accounting and management.

Michigan's First Human Lung Recipient Dies

Michigan's first human lung transplant recipient, Albert Lee Carnick, 50, of Bloomfield Hills, died Sept. 4, three days after the transplant operation at University Hospital, Ann Arbor.

Mr. Carnick failed to survive the initial recovery period, said William N. Hubbard, Jr., M.D., director of the University of Michigan Medical Center. There was no sign of infection or rejection of the new lung, according to Doctor Hubbard, who said the new lung was operating better than Mr. Carnick's own lungs, before death.

Carnick had terminal emphysema when he received the left lung of 17-year-old Richard May of Jackson in a six-hour operation Sept. 1. May was fatally injured in an automobile crash.

U-M, MHA To Lead New Project To Train Coronary Care Nurses, Doctors

A new project to train doctors and nurses for the specialized care of coronary victims will be led by the University of Michigan and the Michigan Heart Association, under a \$484,520 grant from the W. K. Kellogg Foundation of Battle Creek.

The foundation has committed an additional \$300,000 to assist community hospitals in building and equipping coronary care units after the professionals are trained.

The U-M Department of Postgraduate Medicine will provide overall administrative coordination for the effort, and will help sponsor seminars for hospital administrators and trustees dealing with coronary care.

The three-year Kellogg grant will pay the salaries of a cardiologist, a nurse specializing in coronary care, a field director, a coordinator, and an evaluator, along with clerical help. It will also pay for equipment and procedure research and development, teaching materials, travel, office equipment and supplies, computerized data processing and consultation.

Hospitals with 50 to 200 beds will receive the major attention of the new program. There are 122 such hospitals in Michigan, and 93 of them do not have CCUs or intensive care units with coronary facilities. The Upper Peninsula has no coronary care or intensive care units and northern lower Michigan has only six.

MARMP Creates New Position, Approves Blodgett Program

At its mid-summer meeting, the Board of Directors of the Michigan Association for Regional Medical Programs (MARMP) elected an acting vice chairman of its Regional Advisory Group, approved a new project and adopted guidelines to help develop its continuing education programs for medical professionals.

Anson Hedgecock, of Jackson, vice president of the Consumers Power Co., was elected acting vice chairman, a new position created by MARMP at the request of its Regional Advisory Group chairman Michael F. Brennan, M.D., Detroit.

The Board of Directors approved a project submitted to MARMP by Blodgett Hospital, Grand Rapids. The hospital calls its project a Demonstration of an Innovative Approach to a Contin-

uing Medical Education System. The Regional Advisory Group of MARMP approved the project to be submitted to Washington, D.C., where it is now being reviewed by the Division of Regional Medical Programs of HEW.

Although MARMP already has several continuing education programs for doctors, nurses and other health professionals in progress, its board at the recent meeting adopted some guidelines to help directors of the programs prepare and review their programs to make sure they are following the directions MARMP would like them to take.

The guidelines help directors set up their programs and then be able to evaluate whether their pupils are learning, rather than dictating the content of the programs.

NEW CHARLES MOTT CHILDREN'S CENTER DEDICATION OCT. 19

The official dedication of the new Charles Mott Children's Center at the University of Michigan is scheduled for 3 p.m. Sunday, October 19, at Towsley Center for Continuing Medical Education, the U-M.

Charles Mott himself will present the building, to be accepted by William N. Hubbard, Jr., M.D., dean of the U-M Medical School. A reception for university officials and invited guests will follow.

The building will be occupied Oct. 1, and in addition to being a medical center, will serve as a location for seminars and orientations. An earlier open house is scheduled for university medical center personnel, university employes and townspeople.

MSMS Members To Direct Seminars

MSMS members are local coordinators for a series of monthly seminars to be conducted September through May in seven Michigan cities. The seminars, for physicians and para-psychiatric professionals, are to study emotionally disturbed families and are being directed by Leonard Rosenzweig, M.D., Director and Chairman, Department of Postgraduate Training, Michigan Society of Psychiatry and Neurology, Grand Rapids.

The seminars, from 1 to 5 p.m. one afternoon each month, will be held in Alma, with Jack Stack, M.D., coordinator; Flint, Mehmet Ekinci, M.D.; Grand Rapids, Doctor Rosenzweig; Kalamazoo, Cyril J. Curran, M.D.; Lansing, H. C. Tien, M.D.; Saginaw, Victor W. Kershul, M.D., and Jackson, Warren S. Wille, M.D.

Bronson Hospital Clinical Conference On Oct. 16

"Applications of Immunization in Present-Day Medicine" is the theme of the tenth annual Clinical Conference at Bronson Methodist Hospital scheduled Oct. 16 in Kalamazoo.

Invitations are out to physicians in southwestern Michigan to attend the conference, which will begin with registration at 8 a.m.

Speakers will include Israel Tenn, M.D., assistant professor of surgery at the University of Colorado School of Medicine and assistant chief of surgical services at Denver VA Hospital; John S. Nagarian, M.D., professor and head, Department of Surgery, the University of Minnesota; Eugene V. Barnett, M.D., associate professor of medicine, the University of California at Los Angeles, and Chester M. Southam, M.D., associate professor of medicine at Cornell University and an affiliate of the Sloan-Kittering Institute of New York City.

MSMS Fall PG Course Schedule

The schedule for the Fall Postgraduate Programs planned across the state by the MSMS Committee on Postgraduate Medical Education has been completed. Following are the places and dates:

Oct. 7 — Battle Creek
Oct. 13 — Houghton
Oct. 13 — Sault Ste. Marie
Oct. 14 — Escanaba
Oct. 14 — Ironwood
Oct. 15 — Iron Mountain
Oct. 15 — Muskegon
Oct. 16 — Marquette
Oct. 21 — Lansing
Oct. 23 — Alpena
Oct. 29 — Grayling
Nov. 5 — Livingston County

(Howell)
Nov. 7 — Ottawa County (Holland)
Nov. 13 — Midland

Nov. 13 — Petoskey



ROBERT J. MASON, M.D. PRESIDENT, 1969-70

New Approaches Must Be Explored To Medicaid Problems

As president of MSMS and as a member of the Medical Advisory Committee to the Michigan Department of Social Services, I am deeply concerned about many aspects of the Medicaid program in Michigan.

The medical profession in Michigan, I believe, should respectfully request the Michigan Department of Social Services, Michigan Legislature and the Governor to consider extensive changes and reforms in the present Medicaid program which discourage many doctors from participating.

I don't pretend to know the best answers but the medical profession, the medical society and the government agencies must explore some new approaches.

At present most Medicaid recipients are obtaining excellent medical care from private-practice physicians, but these doctors who have worked the hardest and longest to serve these people have been abused and crucified, I feel. Many of these physicians for years have been serving the poor with little or no concern about repayment, but now when Medicaid covers their fees they have been exposed for earning more than \$25,000.

MSMS OFFERS its full cooperation in determining ways to adequately serve more of the Medicaid recipients and in turn work to take some of the Medicaid burden off the shoulders of those few doctors who practice full-time in depressed areas and/or care for most of the disadvantaged.

In commenting on recent charges that physicians are abusing the Medicaid program, I can assure the public that most doctors treating public aid patients have indeed earned the money; and they could make twice as much in the suburbs and

not have to contend with all the government red tape that goes with Medicaid.

These physicians because of their extreme dedication stay in medically-deprived areas because they are willing to work twice the average working day and absorb non-reimbursable expenses in order to provide service when it is desperately needed.

New ways must be developed to improve the delivery of health care in the depressed areas. Let me suggest only two:

LEADERS in the medical profession in Michigan, Wayne County and other counties are exploring the possibilities of establishing outpatient health clinics in medically-indigent areas which might be staffed by part-time private physicians from other areas. There are areas in Michigan — not only in ghetto areas but in suburban, smalltown, and rural sections where there just are not enough physicians today to serve all the residents — whether Medicaid recipients or not.

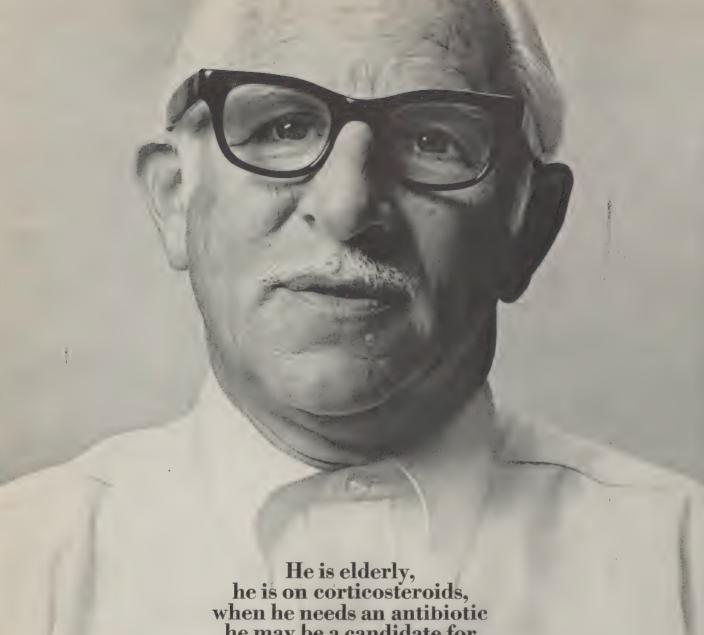
There is growing interest among physicians to take extraordinary methods to help solve these shortages. I would estimate that between 30 and 60 percent of the physicians in Michigan would work a certain number of days each month in medically-depressed areas. Doctors serving at such outpatient clinics could be reimbursed — and properly so — for their normal fees would be provided through the Medicaid program.

In addition to possible clinics in various areas of the state, some of our medical leaders are exploring the possibilities of mobile units that could travel close to the families who need to be motivated and encouraged to use new preventive health measures such as multiplastic screening, etc. Social workers tell us that motivation may even be a bigger problem to solve than changing our usual procedures to provide health care services.

Certainly there are other ideas that merit consideration. Constructive solutions to the problem of health care for the indigent must be found. No one solves the acute situations by leaking names to the press of physicians who have earned \$25,000 or more from Medicaid.

Robert J. Mason, M.D.





when he needs an antibiotic he may be a <u>candida</u>te for

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units **CAPSULE-SHAPED TABLETS Lederle**

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN -the broad-spectrum therapy that prevents monilial overgrowth.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Con-

stant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system-anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin-maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney-rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare) Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood, Enamel hypo plasia has been seen in a few children. If adverse reaction or idio-yn crasy occurs, discontinue medication and institute appropriate therapy Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, food and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

LEDERLE LABORATORIES, A Division of American Cyanamid Compan Pearl River, New York

INFORMATION

FOR CONTRIBUTORS

- Address scientific manuscripts to the Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.
- 2. Submit original, double-spaced typewritten copy and two carbon copies or photo copies on letter size $(8\frac{1}{2} \times 11 \text{ inch})$ paper.
- 3. On page one, include title, authors, degrees, academic titles, and any institutional or other
- 4. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide a latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or
- 5. Illustrations should be submitted in the form of glossy prints or original sketches from which cuts, or plates, will be made by Michigan Medicine. Michigan Medicine will pay the first \$25 of the engraving bill, and the authors shall pay the balance. An estimate of the cost will be submitted to authors before cuts are ordered.
- 6. References will ordinarily be limited to seven in number. Exceptions may occasionally be
- 7. Contributors will be notified as soon as practical if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.
- 8. Articles should ordinarily be less than four printed pages in length (3000 words).
- 9. References should conform to Cumulative Index Medicus, including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.
- 10. Specify address to which galley proofs should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.
- 11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.
- 12. It is understood that material is submitted for exclusive publication in Michigan Medicine.

Michigan Medicine

IN THIS ISSUE

SCIENTIFIC ARTICLES

- 1013 The Cholera Epidemic in Detroit, 1832 and 1834; Irving F. Burton, M.D., F.A.A.P., F.A.C.P.
- A Research Protocol Review Committee for the State of Michigan: Ross V. Taylor, M.D., Chris J. D. Zarafonetis, M.D., Edward A. Carr, Jr., M.D., Lawrence H. Power, M.D., Park W. Willis, III, M.D., and Philip A. Riley, Jr., M.D.

 Cervical Cerclage; N. S. Rangarajan, M.D., C. H. Wright, M.D., H.
- Amirikia, M.D.
- 1033 The Use of Thioridazine in a Comprehensive Mental Health Program; Ahmad Kafi, M.D.
- 1037 Michigan Launches Rubella Vaccine Campaign: John L. Isbister.

SPECIAL ARTICLES

- 1038 Review of Detroit Doctor's Book on Government; Thomas J. Heldt, M.D.
- The John Birch Society and Sex Education; Brooker L. Masters,
- Michigan Students to Have Superior Health Education; E. Gifford Upjohn, M.D.

GOVERNMENTAL MEDICAL CARE PROGRAMS.

Pages 1051, 1052

PRESIDENT'S PAGE

1007 New Approaches Needed to Medicaid Problems: Robert J. Mason. M.D.

PHOTO SECTION, Pages 1057-1060, Inclusive

OTHER FEATURES

- 1003 **Breaking News**
- Officers' Page
- Monthly Surveillance Report 1022
- AMA-ERF Report 1032
- 1045 **Our State Society**
- 1045 Mediscene
- 1048 **Council Minutes**
- 1066 Index to Scientific Articles
- 1071 Ancillary
- 1076 Mailbag
- 1078 Legal
- **Editorial Views** 1087 1092 **News Briefs**
- 1094 **County Societies**
- 1098 In Memoriam
- 1102 Notes and Quotes

NEXT MONTH

The November issue of MICHIGAN MEDICINE will commemorate the 100th anniversary of the founding of University Hospital in Ann Arbor. Special articles written by University of Michigan faculty members and physicians will trace the history and accomplishments of the hospital, accompanied by photographs and artwork.

MICHIGAN MEDICINE is the official organ of the Michigan State Medical Society, published monthly under the direction of the Publication Committee. Published Semi-Monthly, Trimonthly in November and December; 26 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, \$9.00; single copies, 80 cents. Additional postage: Canada, \$1.00 per year; Pan-American Union, \$2.50 per year; Foreign, \$2.50 per year. Printed in USA. All communications relative to manuscripts advertising news exphanges atc. munications relative to manuscripts, advertising, news, exchanges, etc., should be addressed to Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351. O 1969 Michigan State Medical Society.

Patient comfort Ce

Patient comfort in chronic constipation is enhanced by restoration of normal pattern of evacuation.

- ☐ Gentle neuroperistaltic stimulation is mediated through the Auerbach's plexus in the colon
- ☐ Aids in rehabilitation of the constipated patient by facilitating regular elimination
- No laxative tolerance or rebound constipation reported in clinical experience
- Even many previously intractable cases have been successfully treated with SENOKOT preparations
 - ☐ Virtually free of side effects at proper, individualized dosage levels
 - ☐ Dosage may be gradually reduced and eventually discontinued in many cases, upon restoration of normal pattern of elimination
 - **Dosage:** (preferably at bedtime) Adults: 2 tablets (max. 4 tablets b.i.d.). Children: (over

60 lb.) 1 tablet (max. 2 tablets b.i.d.). Supplied: Bottles of 50 and 100 tablets. Purdue Frederick

The Purdue Frederick Company, Yonkers, New York 10701

Senokot Tablets



MICHIGAN STATE MEDICAL SOCIETY

120 West Saginaw (P.O. Box 152) East Lansing, Mich. 48823 Area Code 517, 337-1351

(Note: This October issue was on the presses while the Annual Session was underway in Detroit, so the following lists are those for 1968-69. The November issue will carry the names of the new officers and new councilors.)

PRESIDENT James J. Lightbody, M.D Detroit
PRESIDENT-ELECT Robert J. Mason, M.D Birmingham
SECRETARY Kenneth H. Johnson, M.DLansing
ASST. SECRETARY Brooker L. Masters, M.D Fremont
TREASURER John R. Ylvisaker, M.D Pontiac
ASST. TREASURERC. Allen Payne, M.D Grand Rapids
SPEAKER James B. Blodgett, M.D Detroit
VICE-SPEAKER Vernon V. Bass, M.D Saginaw
PAST PRESIDENTBradley M. Harris, M.DYpsilanti
COUNCIL CHR Ross V. Taylor, M.D Jackson
VICE-CHAIRMAN Ralph R. Cooper, M.D Detroit
COUNCILORS:
Sidney Adler, M.D. 1st Detroit

	it. Cooper,	M.D Denoit
COUNCILORS:		
Sidney Adler, M.D	1st	Detroit
Ralph R. Cooper, M.D	lst	Detroit
Don W. McLean, M.D	1st	Detroit
Milton R. Weed, M.D	lst	Grosse Pointe Park
Robert K. Whiteley, M.D	1st	Detroit
Ross V. Taylor, M.D	2nd	Tackson
Harvey C. Hansen, M.D	3rd	Battle Creek
Don Marshall, M.D	4th	Kalamazoo
John R. Pedden, M.D	5th	Grand Rapids
Harold H. Hiscock, M.D	6th	
John J. Coury, M.D	7th	Port Huron
A. Carl Stander, M.D	8th	
Robert V. Daugharty, M.D	9th	Cadillac
Edward H. Rodda, M.D	10th	
Brooker L. Masters, M.D	11th	Fremont
Wm. A. LeMire, M.D	12th	Escanaba
J. Robert Franck, Jr., M.D	13th	
Harold F. Falls, M.D	14th	Ann Arbor
Sydney Scher, M.D	15th	Mt. Clemens

EXECUTIVE DIRECTOR...Hugh W. Brenneman East Lansing ASSOCIATE EX. DIR..... Warren F. Tryloff.... East Lansing GENERAL COUNSEL.....Lester P. Dodd......Detroit LEGAL COUNSEL..... A. Stewart Kerr..... Detroit ECON. CONSULTANT..... Clyde T. Hardwick...... Detroit HISTORIAN..... Wm. J. Stapleton, Jr., M.D. Detroit ASS'T HISTORIAN...... Wm. M. LeFevre, M.D. Muskegon SCIENTIFIC EDITOR John W. Moses, M.D., Detroit

EXECUTIVE EDITOR Herbert A. Auer

MANAGING EDITOR **Judith Marr**

ASSOCIATE SCIENTIFIC EDITORS

Frederick J. Cady, Jr., M.D., Surgery Saginaw

Robert M. Daugherty, M.D., Basic Science East Lansing

Harold E. De Pree, M.D., Medicine Kalamazoo

Dean C. Elliott, M.D., Otolaryngology Petoskey

Tommy N. Evans, M.D., Obst.-Gyn. Detroit

E. Richard Harrell, M.D., Dermatology Ann Arbor

Dorin L. Hinerman, M.D., Pathology Ann Arbor

Samuel D. Jacobson, M.D., Medicine Detroit

Benjamin Jeffries, M.D., Psychiatry Detroit

Raymond S. Kurtzman, M.D., Radiology

Detroit A. Martin Lerner, M.D., Medicine **Detroit**

George H. Lowrey, M.D., Pediatrics Ann Arbor

Carl A. Moyer, M.D., Surgery Baraga

Charles E. Parkinson, M.D., Radiology Battle Creek

John C. Pierce, M.D., Medicine **Grand Rapids**

Frank H. Power, M.D., Surgery Traverse City

J. G. Turcotte, M.D., Surgery Ann Arbor

Alexander J. Walt, M.D., Surgery Detroit

Park W. Willis, III, M.D., Medicine Ann Arbor

Richard E. Wunsch, M.D., Medicine Traverse City

Publication Committee

Brooker L. Masters, M.D. Harvey C. Hansen, M.D. William A. LeMire, M.D. Don Marshall, M.D. Don W. McLean, M.D. Edward H. Rodda, M.D. Milton R. Weed, M.D.



The Cholera Epidemic in Detroit 1832 and 1834

BY IRVING F. BURTON, M.D., F.A.A.P., F.A.C.P. HUNTINGTON WOODS

In 1832 the City of Detroit was a small frontier settlement of about 3500 people. Founded as a fur trading post by the French in 1701, the City gained further importance as a way station for the lake boats that came from Buffalo and paddled up to Fort Mackinac and then around the crest of the lower peninsula to the ports of Wisconsin and to Fort Dearborn—later to become Chicago.

Situated in almost virgin territory, Detroit sat in the midst of a paradise of nature, the equal of which will probably never again exist. The endless hardwood forests teeming with wildlife, the countless lakes covered with wild fowl and filled with an apparently inexhaustible supply of game and food fish are only memories now with a few fragments preserved here and there in the State and National Parks.

If we could be transported back through time and view the village with our modern eyes, we would find that those early Detroiters had already made a start in despoiling their surroundings. A total absence of any knowledge of the rudiments of sanitation and public health would be apparent and we would find that life at that time in Detroit was less than romantic. The city lay on a small bluff overlooking the Detroit River, but between the settlement and the water, garbage and refuse lined the banks bearing testimony to the years of accumulation. The Savoyard River, which formed one side of the triangle upon which the original fort was founded and which still flows under the Buhl Building, was no more than a large uncovered sewer filled with stagnant water and choked with refuse and raw waste.

With the world's largest supply of fresh water flowing past in the inexhaustible Detroit River, Detroiters drank water which was brackish and often thoroughly contaminated.

Drinking water was obtained in one of three ways, the most direct being from the public dock. This was located at the foot of Randolph Street not far from the Detroit-Windsor Tunnel of today. There was a pump at the end of the dock where barrels and casks were filled. Private individuals delivered the water to customers on regular routes. There was also a large plank and brick reservoir

on a Fort Street lot which was filled by a small steam pump. A few outlets were maintained in the center of the city. The pipes were made of hollowed wood and were held together by metal thimbles.

Most of the inhabitants used wells which were either private or public. Because Detroit was low and marshy, drainage was poor and stagnant pools formed everywhere. Outhouses were placed without any thought of their relationship to the wells, so that direct contamination of the water was the rule rather than the exception.

Detroit had three weekly newspapers in 1832, The Courier, the Detroit Journal and Michigan Advertiser, and The Democratic Free Press. These newspapers covered a wide variety of topics similar to our present newspapers and, despite poor means of communication, world-wide news cover-

The sketch below helps to tell the story about "The Great Plague" in the booklet Your Capitol and Mine, A Story of Michigan's Government for Young Readers by Ellen C. Hathaway and published by the Michigan Historical Commission. The illustrator is Marion Boyd Major.



age was surprisingly detailed and complete although much delayed.

Early in the year 1832, these papers begain to devote a considerable amount of space to three seemingly unrelated events: the cholera epidemic in the Near East and Europe, the influx of Irish immigrants to Montreal and Quebec, and the Indian uprising under Chief Black Hawk.

It was not until the heat of summer that these events formed the links of a chain that brought horror and death upon the city, a fate shared by most of the North American continent.

Cholera is a disease of antiquity. Hippocrates described it. It is often prefixed with the terms "Asiatic" or "morbid," the former because of its indigenous habitat and the latter because of its extreme virulence. Indeed, cholera has ranked second only to the bubonic plague in its ability to decimate the human race. As recently as 1934, nearly 300,000 people suffered from cholera, of whom, it is estimated, half perished. Epidemics are still current at the present time. India has always been the prime source of this infection. Prior to English rule, India had many epidemics of cholera, but they had always been confined within the country's borders.

However, in 1816, due to improved communications with the outside world effected by the English, the cholera epidemic passed beyond its usual confines and spread to parts of Asia and Africa before it died out. In 1826 a severe outbreak began in the delta area of the Ganges and spread throughout India with unusual speed. In 1830 it literally exploded beyond the borders and spread throughout the Near East and Southern Russia. In 1831, 50,000 pilgrims converged on Mecca. Within a few weeks 20,000 of them were sick or dying and

the others were fleeing home in panic, spreading the cholera to the entire Moslem world. From the south of Russia, it traveled to Moscow and thence to the Western European countries. The great cities of Paris, London, and Berlin were soon counting their dead in the thousands every day.

Overcrowded Ships Bring Irish — And Cholera to Canada

In 1832 the cholera epidemic was spreading rapidly throughout Ireland. At that time the potato famine was also causing widespread hardship. Starving Irish began to leave for the new country of America by the many thousands. Friends, charities, clergymen, and communities pooled funds to buy passage for their starving neighbors. Between May and June of 1832, the Detroit papers reported that 45,000 people, almost all of them Irish, passed up the St. Lawrence River to Quebec and Montreal.

The passenger boats took between 36 and 60 days to make the Atlantic crossing. Steerage could be had for as little as £3. In order to "make out" financially, the ship owners overcrowded the boats. Comfort was not part of the passage. Ships that could carry 150 people comfortably would carry as many as 500. The space between decks were rarely over 5½ feet. The aisles were hardly more than 5 feet wide in many ships, with double and triple rows of berths on each side. The berths were made of rough planks, ten feet wide and 5 feet long. They "accommodated" six adults. Often, the passengers had to sleep in shifts. The baggage and incidental possessions were placed in the aisles or wherever a scrap of space could be found.

There were no sanitary facilities on the ships worthy of the name. There was no water for bath-



Cholera came to Detroit and other southeastern Michigan ports from passengers on the many ships sailing in and out every day. This painting by William J. Bennett shows the busy

Detroit river. (From Pictorial History of Michigan: The Early Years by George S. May and published by Eerdmans Publishing Company)

ing and no heat, inasmuch as fire was rarely allowed below decks. Water seeped through the side of the boat and dripped through the decks and timbers. Bedding crawled with vermin. Ventilation was obtained by means of a small windsail at each of the hatches. During a storm, these hatches were battened down and people, baggage, slop jars, and mal de mer were tossed around for days on end — all in pitch darkness. When released at the end of a storm "they (the passengers) would run to the decks crazed with terror."

In June 1832 the Detroit papers reported that the ship *Carricks* from Dublin arrived June 3 at Quebec with 32 dead of cholera. This was not the first case of cholera reported but it left no doubt that the disease was now coming over in force. Many of the passengers of the *Carricks* disembarked and continued on to Montreal on the steamboat *Voyageur*. This boat, too, was horribly overcrowded and almost capsized in a storm.

To make things worse, several passengers came down with the disease and some of them died. They and their personal belongings were jettisoned. As an ironic sidelight, a Canadian farmer of Sorel by the name of LaTour waded out and salvaged one of the mattresses tossed overboard. He died of cholera within 24 hours; the rest of his family shared his fate shortly after.

In April 1832 a few Sauk and Fox warriors, who were later joined by members of the Winnebago and Pottawatomi tribes, under a minor chief called Black Hawk, crossed the Mississippi River and began to grow corn in the Rock River Valley, once their old home. There were no more than a thousand of them, of whom 600 were women and children. This catalyzed a concentration of American troops far in excess of reason. Governor Reynolds of Illinois called into service a total of over 5,000 volunteer militia.

Troops Heading for Black Hawk War Get Cholera on Ships Going Through Great Lakes to Chicago

On request, Governor Mason of Michigan called for 300 volunteers and, when they were raised, placed them under the command of General John R. Williams, for whom the present John R Street in Detroit is named. Meanwhile federal troops were sent in support—the Sixth Infantry from Jefferson Barracks, Missouri; the First Infantry from Prairie du Chien under Colonel Zachary Taylor; the Fifth Infantry at Fort Mackinac, and also the Fourth Infantry from Baton Rouge Barracks, Louisiana. In addition, troops were deployed from the eastern seaboard for whom transport had to be provided.

The Federal Government contracted for four lake vessels to take the troops under the command of General Winfield Scott from Buffalo to Fort Dearborn. Each vessel was hired at a cost of \$5,500, which was to include everything but the

officers' meals. The Henry Clay under Captain Walter Norton and the Sheldon Thompson under Captain Augustus Walker left Buffalo on July 2, the other two vessels following two days later. The trip took four days to complete. The Sheldon Thompson carried General Winfield Scott, his staff, six companies of artillery and two companies of the Second Infantry from Fortress Monroe. The Henry Clay carried three companies of artillery and four companies of recruits, a total of 420 passengers.

The chief surgeon, Doctor Josiah Everett, was on the Sheldon Thompson and the assistant surgeon, Doctor Robert E. Kerr, was on the Henry Clay. At the time of departure, no cases of cholera had been reported in Buffalo, although the Henry Clay had been used as an immigrant ship to carry passengers from Quebec to Montreal. Before this commission from the Government, it had been thoroughly cleaned according to the best standards of the day and disinfected with chloride of lime.

On July 4, Colonel Twiggs, commanding officer of the *Henry Clay*, was notified that one of the men was severely ill and by the next day, he was reported dead.

There was no doubt that it was cholera.

The boat, according to custom, fired a cannon near Sandwich Point to notify the city of Detroit of its arrival. Two citizen passengers disembarked at Detroit, but the vessel was ordered by the mayor to go up the river to Hog Island, now Belle Isle, and await further instructions. Meanwhile, several more cases were reported on the vessel. General Scott arrived shortly after on the Sheldon Thompson and when apprised of the situation ordered the Henry Clay to follow him to Fort Gratiot, the present Port Huron. By this time the decks of the Henry Clay were covered with the dead and dying, so that it was deemed best that a landing be made a mile below the Fort. A drenching rain was falling.

In sheer panic, over 150 of the soldiers deserted the ship and fled into the wilderness. Days and weeks later, travelers described roads and paths strewn with dead and dying soldiers, many partially eaten by wolves and hogs. Colonel Twiggs himself ordered the cadets from West Point to flee and make their way home.

After some regrouping of the troops, the *Henry Clay* was released from its contract and returned to Buffalo. Ironically, it was the *Henry Clay* that brought cholera to Cleveland on this return voyage.

Meanwhile the Sheldon Thompson with General Scott continued on to Mackinac Island, there to start an epidemic which caused all the non-military inhabitants to flee to the mainland.

Scott himself went among the sick, helping and encouraging the men. He also felt that intemperance was the prelude to the disease and therefore

ordered that any man found intoxicated should dig a grave his own size with the understanding that further drinking would result in the drunkard's filling it himself.

By the time the ship reached Fort Dearborn at the mouth of the Chicago River, a total of 88 men had died. The ship's captain described the water as so crystal clear that the ship had to keep shifting anchorage because the bodies of the victims that were cast overboard (21 in number) could be seen by their apprehensive fellows on deck.

The campaign closed on August 2 with a complete rout of the Indians. The Indians were so badly outnumbered that they tried desperately to surrender, but the momentum of the whole campaign required that all should perish but a pitiful band of 150.

General Scott lost about 500 men with cholera. Only a few were lost in battle. Nobody knows how many volunteers were stricken.

There were a number of notables in the Black Hawk campaign: Captain Abraham Lincoln of the volunteer militia, who was ordered to by-pass the area of the regular troops stricken with cholera; Major George Washington Whistler whose father was the founder of Chicago and who himself was the father of James Abbott McNeil Whistler, the famous artist; and an army surgeon, Doctor William Beaumont, then stationed at Fort Crawford. It was from here that the disease spread down the Mississippi.

General Scott was greatly distressed. He wrote, "I am fully aware of the heavy responsibility that rests upon me for the spread of a dreadful malady among the troops under my orders, and through them prematurely among the population of this immense valley. I have never regarded myself as having been born to be a curse to my country."

He was as powerless to stop the epidemic as were the Indians. The Winnebagos shot their guns toward the West at sunset to kill the cholera.

All this time the city fathers of Detroit and the Territory of Michigan had been waging a war of a different kind. They, too, read the newspapers. On June 26, a Board of Health, consisting of Drs. Chapin, Rice and Whiting, was appointed. They immediately called a meeting. They recommended certain measures relevant to the prevention of the disease, and its treatment, if it should come.

The next day Mayor Levi Cook issued a proclamation forbidding vessels from coming nearer than a hundred yards from shore until they had been inspected by the board of health. At a public meeting of the same date the city voted to raise by tax such sums of money as might be necessary to meet the emergency and to proceed with plans to erect a hospital. One thousand dollars was voted for these purposes.

The Board of Health then divided Detroit into



During the cholera epidemic of 1832 in Detroit, the upper story of the capitol building for the Michigan territorial government was used as a hospital. The capitol, featuring Greek revival architecture, was erected in 1805, and was used later as a school building until it burned in 1893. (From **Pictorial History of Michigan: The Early Years** by George S. May and published by Eerdmans Publishing Company)

four districts and citizens were appointed in each of these districts to carry out all sanitary regulations. Chloride of lime was made available to all citizens at city expense. This was stocked at the store of W. L. Newberry, Esq. Detroit felt that it was ready to cope with the cholera.

Detroit Board of Health Urges Residents Stay at Home; Cucumbers Blamed as Cause of Cholera

On July 11 the Detroit newspapers reported the deaths of the two men who had been citizen passengers on the *Henry Clay*. They also reported the deaths of two men who had no known contact with the ship.

The Board of Health with great haste reassured the mayor and council that one of the victims was a man of intemperate and filthy habits who had wandered from one tippling shop to another. People were urged to stay at home and not flee the city. To reassure the public, it was announced that only 1 in 15 people of sober, temperate, cleanly, calm and fearless nature are victims of the cholera.

In a more positive gesture, Mayor Cook announced that he and some of Detroit's leading citizens, J. M. Howard, Lawyer Harding, Thomas Palmer, A. P. Moorman, A. H. Stowell, and Sidney L. Rood would personally take care of those who would be so unfortunate as to become victims of the disease.

For immediate use, the upper story of the Capitol building was converted into a hospital.

It might be appropriate at this point to describe the cholera. Its victims die with agony and horror to themselves and to onlookers.

An excerpt from a letter written by Assistant Surgeon Samuel B. Smith to a friend may convey some of this dread and terror aroused by this "loathesome" disease. ". . . . the face was sunken, as if wasted by lingering consumption; perfectly angular, and rendered particularly ghastly by the complete removal of all the soft solids, and their places supplied by dark lead lines; the hands and feet were bluish white, wrinkled as when long macerated in cold water; the eyes had fallen into the bottom of their orbs; and evinced a glaring vitality; but without mobility; and the surface of the body was cold and bedewed with an eely exudation. I stood gazing in mute horror upon the revolting object, when a sudden spasm convulsing his limbs caused him to screech in a voice so unearthly that I involuntarily covered my ears with my hands . . . and he expired in the fifth hour . . ."

Medicine was still primitive. Each doctor and each community had its own favorite tried and true remedy. The theory and philosophy of medicine of that period taught that disease was caused by an imbalance of body fluids or humors as they were then called. If the balance could be restored, the disease could be cured. Inasmuch as they did not know how to add to deficient humors (as in our present concept of water and electrolyte balance), they removed what they felt were excesses. This was done in several ways through the body pores and apertures. Bleeding was of common usage and dated back to the early barber-surgeon. Emetics, purgatives, and laxatives were used to empty the intestinal contents from either end. Profuse sweating was used to cleanse the pores.

When the patient with cholera was first seen, he was immediately bled, provided that he was not in shock and still had some circulation. In cholera there is marked vomiting and diarrhea so that purging was not always used. Friction rubs and skin irritants were applied to the body to bring the heat from the deeper layers of the body to the

Receis to for Cholora

Inchin Camphor 2 3

Time Cayena 2 Drahus

Time Layena 2 Drahus

Time Imager 1.07

Essence Peppermint 2 B

Stoffmais Anodine 2 B Ming

Dose a table Spoonful in a little water for

on Adult - This is very shoring and hot began

From a chieb a few drops will help drown have

A small dose will Check divishora + The Le D

Cases of Cholora will ascertained you feeld

Hore to an abouth - I have formed Bristol,

Survey arilla Jay tea Spoonful at a line

good to Check laxing of the Bowels - Specially

if 20 or 30 drops of the above mixture is

added all with little mater therein air hours

At Ills worth

This copy of an 1832 prescription shows one approach to treat cholera. Dr. Randall Rice reported success with bleeding and calomel (a mercury laxative). In 1849 a British physician proved that cholera was transmitted in contaminated water.

surface where it could be dissipated. Thus poultices of flour and mustard were placed on the legs and abdomen and sometimes friction was applied. Ice water and ice were given freely to bring down the temperature. Most physicians had their own favorite routines.

Dr. Randall Rice of the Detroit Board of Health declared on oath that he had saved all of his patients with bleeding and calomel (a mercury laxative).

Diet was considered a most serious subject. For some reason, fresh vegetables, especially cucumbers, were considered harmful. A combination of fresh cucumbers and a glass of cold water in the heat of the day was considered absolutely suicidal. A few that died after this combination were mourned not as victims but as fools.

During this epidemic, even the smallest amount of alcohol was considered conducive to sickness. The papers, as well as the proclamations of the authorities, constantly stressed the do's and don'ts of eating and drinking.

In spite of the vigilant measures and actions taken by the officials, the epidemic gained momentum. By July 18 there were 57 cases of cholera reported with 27 deaths.

The heat of the first weeks of July was particularly intense. This was followed by several days of darkness without the sun appearing and then a period of dismal rains. The world seemed at an end.

Pitch and tar were burned in all the low places of the city and an immense potash kettle was heated in the center of Woodward and Jefferson avenues to drive away the noxious effluvia. The city became blanketed with this black irritating smoke that reduced visibility to a few feet in the lowest places which added to the dismay and terror.

People began to migrate to the suburbs in increasing numbers. The city fathers pleaded with the people not to flee the city, saying that to flee was to try to avoid the wrath of God. It would be much better, they said, for all to remain at home and meet their fate like men. The city fathers spoke thus more from knowledge than from piety.

On July 5, Governor Porter had announced that each town could in its own way try to keep the epidemic out. The wording was loosely construed, and all of the suburban settlements surrounding Detroit took a most liberal interpretation.

In Pontiac and Rochester, armed posses of vigilantes formed and posted themselves on the roads leading from Detroit. The bridges in the area were torn down and barricades were erected. The few travelers already in the towns were forcefully evicted from the hotels and driven away, their baggage tossed after them. A certain Doctor Porter of Pontiac, acting in the great tradition of medicine, went to Detroit in the spirit of public service to learn the latest methods used by his colleagues of the big city. On his return his own townspeople refused him re-entry and he was forced to live elsewhere until the epidemc subsided.

In Ypsilanti the townspeople were as vehement. Armed guards were set up on all the roads from the east and entry was refused to all.

Stevens T. Mason, the boy governor, was traveling from Detroit shortly afterwards. Even he



Mason

thought it advisable not to venture within the limits of the Ypsilanti authorities. He hired a guide, a certain Samuel Pettibone, at the first tavern just east of the town and made a complete detour to its west. On reaching the main road again, it occurred to him if he went on from there it might be a long time between drinks. The last oasis had been three miles

east and there were no other taverns for several miles west. He thought that there might be no serious objection to a traveler coming from the west and so ventured into the town. He was promptly arrested by Eliphalet Turner and taken to the sheriff, Doctor Withington, but, after a stormy argument, he was allowed to go free only if he were to leave the town promptly.



Father Gabriel Richard who arrived at Detroit's St. Anne Church in 1798 and served the community, state and young nation in many ways, died in 1832 a victim of cholera and overwork, while ministering to his stricken fellow citizens. (From **Touring Michigan** by Sister Martha Chambon L'Allier, S.S.J., and published by Hillsdale Educational Publishers)

One of the first acts of the Governor when he returned home was to take away the doctor's commission as sheriff. "Thus do doctors both in war and peace fall in the line of duty."

100 Die in Detroit in 1832 Including Father Richard

Life in Detroit came to a standstill. Everything was closed, including the churches. There was no business transacted, no visiting of friends, no public meetings.

In the deepest despair, the Presbytery set aside the 19th of July as a day of humiliation and prayer. On the same day, the quarantine was lifted by the city fathers on the advice of the merchants, and ships and traders were invited to do business as usual. This day seems to have been the high water mark of the epidemic as it subsided quickly from that time on.

By early August the horror had ceased and the city could take stock of its casualties. About 100 people had died in the Detroit area. Many leading citizens were included: Father Gabriel Richard died, although presumably from overwork; Mary C. Trowbridge and Louis Allard.

By September, cholera, which had been widespread along the eastern seaboard, began to subside and the epidemic was soon over in the northern continent.

There were no cases of cholera reported in 1833. (On July 4, 1833, the papers announced that Chief Black Hawk was in Detroit and was lodged at the Mansion House, the fashionable hotel of the city. By this time, he no longer was the cunning savage beast but a brave and true warrior, conquered only by superior white heroes, Detroiters flocked to the hotel, bringing their children to see and admire the venerable chief. From here he was taken to Washington, D.C., to be adulated on a national scale.)

Cholera Returns to Detroit In 1834; Men Decide Brandy Helps to Protect Good Heath

On July 9, 1834, the Detroit papers sadly announced the death of Governor Porter. Although his death was attributed to bilious fever, some suspected that it was the cholera.

It was almost two years since the epidemic, and although people felt uneasy, they refused to accept the possibility of its return as anything but a bad dream. There was the same feeling of uneasiness expressed in the papers. An editorial reassured the people that there might be a few cases of cholera occurring but only among the intemperate and imprudent. They went on unconvincingly to reassure their readers that the health of the city was good.

As a few more deaths were reported as cholera, they again expressed the opinion that those who died had foolishly exposed themselves to extreme heat and then committed the final insane act of drinking cold water. These deaths, they repeated, were not cholera. However, as the deaths began to mount, the editors lamented belatedly that the cholera had indeed returned to its old haunts but that medical science in its progress had it under control. They advised their readers to stay at home and be comfortable.

On August 1, 1834, cholera struck with savage fury.

By August 13 there were 40 deaths reported at the Protestant Burial Ground and 17 at the Catholic Cemetery. The newspapers of August 20 reported 47 deaths in four days. The bell of the First Presbyterian Church, which tolled for each death, had become so continuous and depressing that on the request of Zachary Chandler, the tolling was discontinued.

Once again the newspapers were filled with do's and don'ts of diet and temperance. Most of the males of the city convinced themselves that some alcohol was of benefit. This led to an orgy of brandy drinking. The newspapers cried out editorially that there were far too many calls for brandy and that they were unwilling to admit that ruddy-nosed gentlemen should get any credit for preserving health when they were really destroying it by becoming inebriate. Among the more genteel, port wine was considered acceptable, although the ladies might take some flagroot tea with a hint of brandy. William Whipple, in writing to his father, noted that "our most temperate man died, I believe because of lack of some stimulant."

One newspaper editorially stated that Negroes were unusually prone to cholera.

Hope was again at low ebb. People were once again fleeing the city only to be met with a ring of hostile suburban villages. Many died while away; many fathers returned to take their families to new homes to find that they had perished in the interim. Again the city was filled with the black oily smoke of burning pitch. Business was completely shut down. The churches were unattended. Mayor Trowbridge sadly announced that the cholera was "not only merely among the laboring, the dissipated, the filthy and reckless portion of the community but among the most temperate, the most cleanly and apparently among the most calm and courageous."

Doctor Rice, whose treatment seemed so efficacious during the first epidemic, was forced to admit sadly that all he had treated this year fared no better than others and "hope left when they all died."

The press also lost all hope. An editorial stated: "What is Cholera?

It is the sword of God.

What is the cause?

The infidelity of the World."

The death toll by August 20 was 153. The populace then turned upon the mayor and council and accused them of doing nothing during this crisis. This was met by a hot rebuttal. The council immediately pointed out the following facts:

- 1. The removal of nuisances.
- 2. More money expended in four months than the two years previously (Not 1832).
- 3. The doctors were to report daily to the mayor (even if they were too tired to do so).
- 4. They had divided the city into four districts and had had nuisances and stagnant pools removed. The mayor had personally borrowed \$300.00 to pay for the chloride of lime inasmuch as the city had exhausted its credit.

5. The chloride of lime was distributed free of charge and not sold as it was maliciously rumored.

Meanwhile, private initiative came to the fore. Friend Palmer and 14 others formed a mutual insurance company to "safeguard," protect, and nurse one another. It demonstrated in the clearest way and most absolute manner that whosoever cooly and courageously pursues the ordinary habits of his life and his daily business may bid defiance to cholera or yellow fever or any other epidemic, and outlive its dangers and its destruction.

Only one member died in consequence of his own folly "in drinking mint juleps and eating green cucumbers as if determined to invite an attack of the disease."

Father Kundig Sets Up Cholera Hospital in Church

No story of Detroit can be complete without mention of Father Martin Kundig. In the darkest of times, he arose to bring hope and dignity back to the city. Father Kundig arrived in Detroit from Cincinnatti in 1833 when Bishop Fredrick Rese came. He was Swiss by origin, born in 1805. People described him as six feet tall with dark eyes and hair, and a face expressive of power, benevolence and enthusiasm. He was a "real" gentleman,

a good musician (played the guitar), a good tenor, and an accomplished linguist. In the very exclusive social circles of the city, he was a welcome addition.

When the epidemic struck, he immediately took full action. The First Presbyterian Church on the present site of the Barlum Tower had just been purchased and was to be moved for the use of the Irish Catholics. This was immediately taken over and made into a cholera hospital (which operated until August 27, 1834).

Bishop Rese contracted with the city to allow them to take care of the sick and dying. A temporary partition was made through the center of the church to provide some privacy for the two sexes. Every other pew was removed leaving space for beds and aisles. In his work, he was aided by the Catholic Female Association, whose roster contained many of Detroit's old family names. Later this group came to be known as the Catholic Sisters of Charity.

The cost of the entire service to the city was \$1,362.85, which included labor and services at the Cholera Hospital, medical attendance, food, merchandise, sexton's services, coffins, and grave digging.

But the trouble did not end there. When the epidemic ended, there were 60 adults, 50 orphans,



Father Martin Kundig, aided by Catholic women, set up a cholera hospital in 1834 in the First Presbyterian Church on the present site of the Barlum Tower in downtown Detroit. (From Stuffed Saddlebags by Rev. Peter L. Johnson; thanks to the Burton Historical Collection of the Detroit Public Library)

and 40 invalids to take care of. It was finally worked out that the Sisters of Charity under Father Kundig would tend them in a rather grisly farm house owned by the city. They were allowed 16¢ a patient per day for care, food, laundry. Both the city and county were bankrupt and by 1839, Father Kundig was \$7,000 in debt. Creditors seized everything, including blankets, cribs, and clothing. Even the Father's guitar was taken from him. After many years he paid off his creditors from his own pocket. His only relief was by a special act of the State Legislature which gave him \$3,000. The American Catholic Historical Researchers publication of January 1898 referred to Rev. Kundig as "The Apostle of Charity in

The epidemic ended abruptly at the end of August, 1834.

A report made by A. E. Hather on September 6, 1834, at the request of the mayor and recorder was submitted to the council.

"I have been at every door or seen one of every family within the limits of the corporation:

Deaths:

Children under 14 years of age Males	75 87
Females	70
Colored persons	9
*	
Cholera	222
Other diseases	57
Citizens	145
Strangers	95
Population Citizens	4,448
Strangers	387
Colored persons	137
	4,973

Cholera was to return again to Detroit and the nation. In 1849, Detroit had 700 deaths recorded and in 1854 there were 259 deaths in July, the worst month.

There were further outbreaks, one in 1866 and again in 1879.

Snow, Pasteur, Koch Solve Cholera Puzzle In 1884 Half Century Later

In 1849, John Snow, a London physician, was able to prove that cholera could be transmitted in contaminated water. In a manner of deduction, more reminiscent of Sherlock Holmes than that of a scientist, he showed that a localized outbreak of cholera in London could be traced to those people who drank water from the Broad Street Pump. The final and clinching proof was when he showed that a woman who was the only person afflicted with cholera in a distant area in London had sent a servant to fetch water from this well because she liked its taste. For the first time some

of the mystery and the superstition associated with cholera outbreaks were dispelled. The final discovery of the causative agent was made a few years later. At this time, Louis Pasteur and Robert Koch, two of the great figures in laboratory research, made fundamental discoveries in bacteriology and immunology. It was Robert Koch in 1884 who headed a research team in India during a cholera epidemic that isolated and identified the causative organism. Thus the mystery of the disease was finally solved 2,300 years after Hippocrates, and a bare one half century after its first visit to Detroit.

APPRECIATION

This article is based on material in the Burton Collection of the Detroit Public Library and the Michigan Historical Collections at the University of Michigan. I owe sincere thanks to Mr. James Babcock, the librarian at the Burton Collection at that time and Mr. Robert M. Warner, the director of the Michigan Historical Collections, Mr. Francis W. Robinson was also of invaluable assistance.

Editor's Comments:

It is interesting to read this article and study medical problems and their management in Michigan a century and a quarter ago. This article, written in an interesting style, has been well researched and is replete with historical data.

> - John W. Moses, M.D., Scientific Editor



MONTHLY SURVEILLANCE REPORT CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH FOR THE FOUR-WEEK PERIOD ENDING AUGUST 29, 1969

	1969 This 4-Week Period	1968 Same 4-Week Period	1969 Total To Above Date	1968 Total Same Date	Total Cases for 1968
Rubella	141	40	3736	1450	1953
Measles	41	11	258	264	352
Whooping Cough	13	26	87	310	429
Diphtheria	-	_			
Mumps	127	93	3904	13103	14655
Scarlet Fever &					
Strep Sore Throat	270	204	6453	7245	10101
Tetanus	1	_	3	2	5
Poliomyelitis (paralytic)					3
Hepatitis	237	120	2052	1376	2356
Salmonellosis (Ollowallia)	70	40	250	440	C1.4
(Other than S. typhi)	72	43	359	442	614
Typhoid Fever (S. typhi)	16	13	4	167	346
Shigellosis Aseptic Meningitis	16 25	13	184 72	50	265
Encephalitis	15	2	73	54	114
Meningococcic Meningitis	3	4	92	67	94
H. Influenzal Meningitis	7	1	41	37	64
Tuberculosis	165	218	1495	1891	2647
Syphilis	261	373	2856	3670	5351
Gonorrhea	1736	1546	12016	11888	18153

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director Michigan Department of Public Health



The Research Clinic inside the Southern Michigan State Prison.

In 1964 the State of Michigan through its Department of Corrections established an unbiased Research Protocol Review Committee which has functioned for the State as a scientifically knowledgeable peer review and advisory committee concerning human research in the prison population. Policies for clinical research involving volunteers from the prison population were firmly established. The unique cooperation of existing state agencies and the medical colleges permitted the formation of an over-all advisory committee which included representatives of the State Department of Corrections, the State Health Department, and the two Michigan Medical Colleges. The establishment and functioning of the Research Protocol Review Committee was established Phase I studies were permitted within the prison population. Since the formation of the Research Protocol Review Committee, in several hundred Phase I and other studies, no serious adverse reaction has yet occurred.

A Research Protocol Review Committee For the State of Michigan

BY ROSS V. TAYLOR, M.D., JACKSON CHRIS J. D. ZARAFONETIS, M.D., ANN ARBOR EDWARD A. CARR, JR., M.D., ANN ARBOR LAWRENCE H. POWER, M.D., DETROIT PARK W. WILLIS, III, M.D., ANN ARBOR PHILIP A. RILEY, JR., M.D., JACKSON

During the past few years new regulations have led to a marked increase in the influence of the Food and Drug Administration on the study and use of drugs in this country. While some problems remain to be resolved, the pharmaceutical industry, the academic community and practicing physicians have, for the most part, made excellent progress towards a satisfactory adjustment to these new regulations.

Unfortunately, it now appears that this complex system may be further complicated by legislative action at the state or national level. Legislation introduced in the New York State Legislature last year would have established a State Commission with authority to control all research involving human subjects. It was proposed that this Commission on Medical Research consist of a

chairman, appointed by the Governor, and 11 other members. The act further provided that "not less than six of those 11 other members shall at all times be non-members of the medical profession." The implications of such legislation are far-reaching and of concern to all who are responsible for developments in clinical pharmacology and therapeutics. The New York State proposal would have placed control of human research in the hands of "non-members of the medical profession." It would also have created an administrative and review mechanism which would intrude on the area of responsibility and authority of hospital directors and professional staffs, deans of medical schools and their faculties (including their respective Committees to study Clinical Research and Investigation Involving Human Beings, and which follow guidelines set forth by the Public Health Service) and prison commissioners and their boards in those situations where inmates volunteer to participate in such studies. Chaos would result should all 50 states create differing laws regulating research on human beings.

ON THE NATIONAL SCENE the recent problems disclosed in the *New York Times*, May 31, 1969, concerning the necessity for the Alabama Board of Corrections to order a halt to the drug testing programs being conducted in the state prisons, resulted in wide-spread adverse publicity and editorials concerning drug testing and research throughout the nation.

The Medical World News in the August 29, 1969 issue, page 13, states: "Partly as a result of recent 'disclosures' in the New York Times, mostly a rehash of earlier stories in the Montgomery (Ala.) Advertiser, and a critical report by the Medical Association of the State of Alabama, FDA Commissioner Herbert L. Ley, Jr., was called before the Senate Monopoly Subcommittee of Sen. Gaylord Nelson (D.-Wis.). Dr. Ley testified that the agency would seek to have expert reviewers



Part of the laboratory and examining rooms of the special facility for research projects at Southern Michigan State Prison.

examine protocols at prisons and other institutions conducting drug studies and monitor the evaluations."

In the American Medical News August 25, 1969 it was reported that Dr. Ley in questioning by a Senate Small Business Subcommittee stated that he planned "to issue a regulation requiring that drug testing in prisons and hospitals be screened by 'peer groups' of physicians, lawyers, and clergymen."

Senator Nelson has introduced a bill that would create a federal center, under FDA auspices, to do all such work.

THESE COMMENTS are not to be construed as criticism of the Legislature of the Commonwealth of New York, which is properly attempting to assure maximum protection for those participating as subjects in human research. In New York, Alabama, and in many other states, there appears to be a need for some means by which drug investigation in humans can continue with adequate safeguards for volunteer subjects outside of university medical centers. At the present time all university medical centers and most hospitals where research involving human beings is performed have review committees assigned this responsibility. But there remains a large group of normal volunteers, often prisoners, for whom similar supervision and protection must be provided. However, the placement of research guidance under uninformed laity would seem ill-advised and impractical.

The State of Michigan has provided safeguards for over five years for its Department of Corrections through its Protocol Review Committee. This description of the history and function of the Committee is presented here in the hope that it may be helpful to others searching for a means of dealing with this problem.

BACKGROUND

The effective use in preceding years of volunteers from the prison population for human research at the Southern Michigan State Prison led to the suggestion by the Upjohn Company in 1961 that a research facility be constructed inside the prison. This suggestion was of interest to the Department of Corrections because serious space problems had limited the research programs that could be conducted in the prison hospital. In November, 1961, Harold L. Upjohn, M.D. and William N. Hubbard, Jr., M.D., Dean of the University of Michigan Medical School, met with the Corrections Commission of the State of Michigan and outlined proposals for the general research program and for the construction of a Medical Research Building within the Southern Michigan State Prison.2

In December, 1961, the Corrections Commission

approved³ in principle recommendations relative to:

- 1. Construction of a facility.
- 2. Participation of inmates. Guidelines stated that participation must:
 - a. Be voluntary in all instances.
 - b. Be based upon informed consent. An agreement between each volunteer and The Upjohn Company informing the inmate of the nature of his participation and the possible associated hazards.
 - c. Include the right to voluntary withdrawal from a study at any time.
 - d. Stipulate the rate of compensation for volunteers.
 - e. Be based on the non-discriminatory inmate participation policy.
- 3. Waiver of liability on the part of the State, the Commission, and its employees.
- 4. Liability insurance.
- 5. Special diet responsibilities.
- 6. Proposed research project review procedure.
- Cost of construction.
- 8. Possession of title of the building.
- 9. Professional staff and custodial control.

In April 1962, the Corrections Commission asked the Director of the Department of Corrections to inform the Parke, Davis Company that the Department was proceeding with the Upjohn Proposal,4 and in May advised the Director to proceed with the Upjohn Project.⁵ In August, the Director reported to the Commission that meetings had been held with the architect to initiate planning for the construction of a Research Building.6 In March, 1963, the Commission reviewed the request of the Parke, Davis Company to join The Upjohn Company in the construction of the Research Building and recommended to the Director that the request be approved.7

EARLY IN 1964, Harold L. Oster, M.D., an Upjohn Company research investigator, and Harold L. Upjohn, M.D., became concerned that the only review of research protocols was within the research department of the Company. An unbiased review mechanism seemed desirable for several reasons including a desire to improve the safety factors of volunteers for the studies, and also the recognition of the problem that in the advent of an adverse drug reaction there might well be criticism of the absence of an unbiased review of the safety of any proposed project prior to initiation of the study. This concern of The Upjohn Company officers coincided with that of the Department of Corrections for the State of Michigan, which has primary responsibility for the safety of all prisoners as wards of the State.

On March 3, 1964, Alexander Z. Lane, M.D., Edward L. Holmes, M.D., Harold L. Oster, M.D., Robert E. Medlar, M.D., Alan B. Varley, M.D., and Mr. Ralph Willy met to discuss the important responsibility of the Company and the State for the safety of inmate volunteers participating in these research projects. They recommended the formation of a Protocol Review Committee to evaluate all medical research projects to be conducted in the State of Michigan within the jurisdiction of the Department of Correction.8 In May, 1964, the Commission approved the appointment of an advisory Protocol Review Committee to assist the Department of Corrections by reviewing research proposals to be carried out on volunteers under jurisdiction of the Department.9

In April, 1964, Mr. Gus Harrison, Director, Department of Corrections, invited five physicians,

One of the ward rooms for in-patient volunteers at the prison research station.



Edward A. Carr, M.D., Joseph A. Preston, M.D., Philip A. Riley, Jr., M.D., Ross V. Taylor, M.D., and Chris J. D. Zarafonetis, M.D., to become members of a Protocol Review Committee.* All accepted and Dr. Taylor was appointed Executive Secretary and was asked to serve as Chairman of the Committee. Each member had skills and knowledge in specific areas which, it was anticipated, would be of importance to the work of the Committee.

In May 1964, Alan B. Varley, M.D., Alexander Z. Lane, M.D., and Chris J. D. Zarafonetis, M.D., met with the Commission to discuss experiences with the development of new drugs. The Commission agreed to volunteer participation by prisoners in experiments involving new compounds if the inmates were fully informed in non-scientific terms of the nature of the experiment and were given permission to withdraw at any time.⁹

THE COMMISSION ALSO recommended the appointment of a special advisory committee to assist in determination of policies concerning human research. This advisory committee was to consist of representatives of the Michigan Department of Corrections, Michigan Department of Health, and the then existing two schools of Medicine. Ernest D. Gardner, Ph.D., Dean of the Wayne State University College of Medicine, William N. Hubbard, M.D., Dean of the University of Michigan School of Medicine and Albert E. Heustis, M.D., Director of the Michigan Department of Health, agreed to serve on this Advisory Committee. Commissioner Duane L. Waters, M.D., was appointed to represent the Commission.

CONSTITUTION OF THE REVIEW COMMITTEE:

The complete statement of purpose and functions of the Protocol Review Committee was as follows:

I. PURPOSE: To review and render an opinion to the Director of the Department of Corrections on the safety and suitability of research protocols submitted by the Parke, Davis or Upjohn companies on studies to be conducted in the prison system of the State of Michigan.

II. MEMBERS: The Committee will be appointed by the Director of the Department of Corrections, shall report directly to him, and will consist of three to five physicians with previous research experience, located in the Michigan area. One member of the Committee shall be appointed Executive Secretary and shall be responsible for the administration of Committee functions.



Defibrillator monitor in Southern Michigan Prison room for special studies.

III. DUTIES: The Committee shall meet once monthly to review all protocols forwarded to the Director of the Department of Corrections by the involved companies. At the discretion of the Executive Secretary, Protocols representing repetition of previously approved studies, studies of previously reviewed drugs with only minor protocol changes, diagnostic procedures, or studies involving no drug or commercially available drugs may be reviewed informally by letter. In such instances recommendation for approval or disapproval may be communicated to the Director of the Department of Corrections without a formal Committee meeting. All protocols involving drugs new to the prison system shall be formally reviewed by the Committee.

IV. STIPENDS: Stipends and expenses (travel) use of consultants, etc. are paid by the State Board of Corrections from a general operating fund provided equally by the Upjohn and Parke, Davis companies.

OPERATIONS OF THE PROTOCOL REVIEW COMMITTEE

The general plan for proposal review and implementation of protocols is as follows:

- a. The company or individual wishing to initiate a research project forwards an appropriate number of copies of the proposed protocol with necessary information to the Director of the Department of Corrections.
- b. One copy remains in the Director's office and copies are forwarded to the Executive Secretary of the Committee for distribution to Committee members.
- c. The Committee reviews the protocol for evidence of medical safety and suitability; one or more representatives of the sponsoring company are present at meetings involving review of protocols submitted by that company and provide any additional information needed by the Committee in its consideration of the protocol.
 - d. The Executive Secretary forwards the recom-

^{*}Dr. Allen R. Hennes was added to the Committee to represent the Wayne State University Medical School. Following Doctor Hennes' untimely death, Dr. Lawrence H. Power was appointed to the Committee. Park W. Willis, M.D., joined the Committee to fill the vacancy created when Dr. Joseph Preston moved to another state.

mendation of the Committee for approval or disapproval (with a brief explanatory note) to the Director of the Department of Corrections as promptly as possible.

e. The Director of the Department of Corrections, after review of the Committee's recommendations, approves or disapproves the protocol by letter to the proposer.

DISCUSSION:

As far as can be ascertained, this working partnership between separate units of State government for the advancement of human research is unique to Michigan. The wisdom of such a partnership is obvious if one considers the responsibilities of each of the concerned agencies. The Department of Health must be concerned with all aspects of public health, the Department of Corrections must be entirely responsible for the imprisoned "wards of the State," and the Medical Schools must be continuously concerned with all aspects of medical research and education.

The first meeting of the Protocol Review Committee on May 22, 1964 was an organizational one. Since June 1, 1964, the Committee has met at monthly intervals to review research protocols and make recommendations concerning them to the Department of Corrections. Protocols have been primarily submitted by the Parke, Davis Company and The Upjohn Company, but also by the R. P. Scherer Corporation, The University of Michigan and the Henry Ford Hospital.

The majority of the protocols have come from two Michigan-based pharmaceutical companies. One hundred and thirty-eight (138) protocols from the Parke, Davis Company and 174 from The Upjohn Company were approved in the first five years.

The usual procedure has been for the Committee and representatives of each pharmaceutical firm to meet together as a group for general discussion. Then the Committee and representatives of each company in turn have a closed session for consideration of the protocols submitted by that firm. Protocols of one company are not, of course, discussed with representatives of other companies. Frequently the Committee has suggestions for modifying protocols to make them more safe for the subjects or to improve the information yield from the study.

It should also be noted that approval of a protocol by the Michigan Protocol Review Committee does not *ipso facto* allow a research project to be initiated. Even after approval by this committee, the recommendation and comments on safety and suitability of the proposed research are given to the Director of the Department of Corrections and his final approval is required before the study can be initiated.

PARTICIPATION BY the prisoners in these investigations within the prison is entirely volun-

tary. No individual inmate is asked to participate. Advertisements are placed in the prison newspaper and volunteers are obtained exclusively by this avenue. Volunteers must initiate their own participation by sending in a request as explained in the advertisement. Inmate participation in such research programs has no influence in consideration for parole or pardon. Payment to volunteers has been set at a low level so that it cannot be viewed as a strong inducement to participation. The attitude of the volunteers, although difficult to evaluate, is in general one of making a contribution to society.

Since April 1, 1964, 18,278 men have been "screened" as possible participants in drug studies. If an inmate meets the medical requirements, he is then eligible for participation in studies at either the Parke, Davis Clinic or Upjohn Clinic.

THROUGH 1968 there were 174 studies involving 5,296 subjects in the Upjohn Clinic. (Table 1.) In the year 1967, as an example of the distribution of the studies, the Upjohn Research Clinic performed 18 Phase I studies, 6 Phase II studies, and 3 Phase III studies. Together these involved 989 subjects for a total of 29,751 mandays.

The Parke, Davis Clinic since March 16, 1964 has had 5,641 volunteers participate in studies.

TABLE 1
THE UPJOHN CO. RESEARCH ACTIVITIES
SOUTHERN MICHIGAN STATE PRISON

Year	No. Studies	No. Subjects
1964	41	1299
1965	33	802
1966	42	1216
1967	27	989
1968	31	990
Totals	174	5296

TABLE 2
PARKE, DAVIS & CO. RESEARCH ACTIVITIES
SOUTHERN MICHIGAN STATE PRISON

Year	No. Studies	No. Subjects
1964	32	638
1965	28	1629
1966	24	1204
1967	20	774
1968	34	1396
Totals	138	5641

TABLE 3
ALL CLINICAL RESEARCH ACTIVITIES
SOUTHERN MICHIGAN STATE PRISON

Year	No. Studies	No. Subjects
1964	73	1937
1965	61	2431
1966	66	2420
1967	47	1763
1968	65	2386
Totals	312	10937

(Table 2) lists the number of studies and subjects at the Parke, Davis Research Clinic tabulated by year. There were 31,907 patient days involving 1,204 subjects in 1966, and 22,102 patient days involving 1,396 subjects in 1968.

From (Table 3) it can be seen that 10,937 volunteer subjects have participated in 312 protocol studies from the inception of the Protocol Review Committee through 1968.

SOME STUDIES do not require screening and some volunteers are used in more than one study. Many volunteers are screened three or four times a year. The physical examinations done prior to a study are sometimes an added bonus to the volunteers through the detection of disease not previously known. At any given time, there are about 1,200 inmates participating in the research program.

Prior to the establishment of the Protocol Review Committee, the study of new compounds was not permitted at the Southern Michigan State Prison. However, since the formation of the Committee, a majority of the protocols have been concerned with Phase I tests. It should be noted further that despite the large number of Phase I studies not a single serious adverse drug reaction has been encountered among the test subjects.

SUMMARY

Whenever prison inmates serve as volunteer subjects in research, safeguards against coercion and careful consideration of the safety of the studies are particularly necessary. As wards of the State, prisoners are entitled to the protection afforded by the existence of a reviewing body comprised of scientifically qualified individuals.

The Michigan Protocol Review Committee is offered as an example of such a reviewing body. The policies and operations of such a reviewing body should be established and monitored by an advisory group of representatives of the concerned governmental and scientific agencies. This insures the qualifications of the members of the reviewing committee and protects against possible coercive practices in the selection of subjects. The advisory group in Michigan has included representatives of the State Department of Correction, State Department of Health, and two of the schools of medicine.

There are alternative arrangements to insure that those conducting research among prison volunteers are held to careful public accountability. One alternative is exemplified by the new State proposal to which reference was made at the outset of this article. The arrangement has as one of its important features the establishment of an entirely new group not composed of experienced scientific investigators and not deriving its authority from agencies or institutions already existing in the state.

The successful operation of a Protocol Review Committee in the State of Michigan, under policies established by an advisory group of representatives of established state agencies and medical schools suggests that the mechanisms such as outlined in the New York proposal, are unnecessary. Without additional legislative action most states could probably establish research review committees similar to Michigan's under authority already implied in their existing legal structures.

That the formula devised in Michigan is successful is attested by the fact that in an experience of over five years duration and in several hundred research studies frequently involving new drugs administered to humans for the first time, no serious adverse reactions have occurred. As far as can be ascertained the State of Michigan was the first to recognize its responsibilities and establish an adequate mechanism which protects the participating volunteers and yet permits the properly directed and necessary continuing human clinical research.

REFERENCES

- 1. State of New York Senate Assembly February S.4015-A A.5586-A An Act: To amend the public health law, in relation to human research.
- 2. Minutes of meeting of the State of Michigan Corrections Commission, November 1-2, 1961.
- 3. Minutes of meeting of the State of Michigan Corrections Commission, December 6-7, 1961.
- 4. Minutes of meeting of the State of Michigan Corrections Commission, May 2-3, 1962.
- 5. Minutes of meeting of the State of Michigan Corrections Commission, May 2-3, 1962.
- 6. Minutes of meeting of the State of Michigan Corrections Commission, August 1-2, 1962.
- 7. Minutes of meeting of the State of Michigan Corrections Commission, March 6-7, 1963.
- 8. Holmes, E. L.: Personal correspondence, 1968.
- 9. Minutes of meeting of the State of Michigan Corrections Commission, May 6-7, 1964.
- 10. Minutes of meeting of the State of Michigan Corrections Commission, June 17-18, 1964.

Ninety cervical cerclage operations were performed on 82 patients with the diagnosis of cervical incompetence during pregnancy. About fifteen percent of their previous pregnancies had resulted in mature births. Following cerclage the yield was 39.25 percent. Operations done after cervix had effaced and dilated partially gave poor results. Forty-eight percent of patients had their cerclage sutures removed after varying intervals following their operations because of rupture of membrane. The significance of this is unknown at the present time.

Cervical Cerclage

BY N. S. RANGARAJAN, M.D. C. H. WRIGHT, M.D. H. AMIRIKIA, M.D. DETROIT

Most premature deliveries resulting from an incompetent cervix are preventable. Early diagnosis and prompt treatment are vital. Successful management requires careful attention to operative technic and postoperative care.

This report concerns a review of 90 cervical cerclages performed on 82 patients at Hutzel Hospital, Detroit, Michigan, from 1962 to 1968. In order to assess the effects of increasing experience with operative technics, the patients were divided into four chronological groups. Each group consists of 25 cases, except group 4 which includes only 15. Ten were still undelivered at the time of preparation of this report.

INCIDENCE

The overall incidence of prematurity during the study period varied between 10.27 and 16.1 per cent (Table I). An incompetent cervix was responsible once out of 159 to 402 deliveries (Table I). Frequency of this diagnosis is directly related to the intensity of the search.

AGE AND PARITY

The four groups resemble each other with regard to the average gravidity (4.88), average age (28.05 yrs. with a range of 19 to 40), and gravidity (1 to 10). Two were primigravidas. (Table II).

PAST OBSTETRICAL HISTORY

The study groups had a total of 350 pregnancies (Table 3). These included 31 pregnancies in which cerclages were done previously. There is a decline in the number of previous mature babies from groups 1 to 4. This may be attributed to

The authors are with the Department of Obstetrics-Gynecology at the Wayne State University School of Medicine, Detroit.

TABLE I
INCIDENCE OF PREMATURITY
AND CERVICAL INCOMPETENCE

Year	Total Deliveries	Prematurity Incidence	Clinical Diagnosis of Cervical Incompetence
1962	3,493	11.45%	1:349
1963	4,441	10.27%	1:234
1964	4,274	11.9 %	1:389
1965	4,021	13.36%	1:402
1966	3,930	16.1.%	1:207
1967-1968	4,138	13.2 %	1:159

TABLE II

MATERNAL AGE AND GRAVIDITY
IN THE FOUR CHRONOLOGICAL GROUPS OF WOMEN

	Groups	Average Age	Average Gravidity	
ı	(1962-64)	27.72	4.44	
11	(1964-66)	28	4.76	
Ш	(1966-67)	28.24	4.4	
IV	(1967-68)	28.26	4.9	
TOTAL (90 cases)		28.05	4.875	

better selection of patients and more accurate diagnosis. The overall percentage of mature babies was 15.21 percent. The previous prematurity and abortion rates were 35.45 and 49.34 percent, respectively. There was a history of premature rupture of membranes in previous pregnancies in 41 or 11.7 percent (**Table 3**).

PREOPERATIVE CERVICAL DILATION

Details of cervical dilation, effacement and length, at the time of surgery, were not available in 18 instances. The cervical dilation in the rest ranged from 1 to 7 cm. No patient whose cervix was more than 3 cm. dilated carried the preg-

TABLE III
PAST OBSTETRICAL HISTORY

Chronological Groups of Women			Birth Weights of Previous Infants 2500 gms 1000-2500 1000						History of Premature Rupture of the Membranes in Past Pregnancies	Total
1		(A)	24	(27.6 %)	28	(32.2 %)	35	(40.2 %)	18	87
		(B)	16	(21.4 %)	23	(31.1 %)	35	(47.5 %)		74
- 11		(A)	20	(16.7 %)	51	(42.5 %)	49	(40.8 %)	7	120
		(B)	15	(13.5 %)	47	(42.4 %)	49	(44.1 %)		111
111		(A)	11	(13.1 %)	22	(25.7 %)	52	(61.2 %)	11	85
		(B)	9	(11.3 %)	19	(24.1 %)	51	(64.6 %)		79
IV		(A)	2	(3.43%)	24	(41.4 %)	32	(55.17%)	5	58
		(B)	2	(3.6 %)	22	(40.00%)	31	(56.4 %)		55
TOTAL										
ALL	350	(A)	57	(15.21%)	125	(35.45%)	168	(49.34%)	41 (11.7%)
	319	(B)	42	(13.20%)	111	(34.7 %)	166	(52.1 %)		

- (A) past pregnancies including cerclage
- (B) past pregnancies excluding cerclage

TABLE IV

COMPARISON
OF SURGICAL TECHNIQUES

		stational age urgery in wee		Surgery, Delivery Interval in weeks			Birth Weight		
GROUP	Shirodkar	McDonald	Average	Shirodkar	McDonaid	Average	Shirodkar	McDonald	
1	21.25	22.90	22.08	11	8	9.5	5# 11 oz	3# 11 oz	
11	19.60	18.8	19.20	12.1	17.25	14.68	5# 1 oz	4# 12 oz	
111	20.0	18.83	20.42	10.4	11.00	10.7	4# 7 oz	4# 2 oz	
IV	16.78	15.67	16.23	15.0	18.5	16.8	4# 1 oz	4# 10 oz	
Average	19.91	19.05	19.48	12.13	13.7	12.6			

nancy to maturity. Cervical effacement varied from 20 to 90 percent.

TIME OF CERCLAGE

The average gestational age at the time of cerclage was 19.48 weeks in all groups. An increasing tendency to perform the operation earlier is shown by the lowest figure in group 4 of 16.23 weeks (Table 4).

TECHNIC AND COMPLICATIONS

Shirodkar's² operation was performed 59 times and McDonald's¹ 31 times. Post-operatively, urinary tract infection occurred in 4. Resuturing because of a "slipped suture" was necessary in 2 following a Shirodkar and in 1 following a McDonald operation. Sutures were found to have slipped after 2 days, 2 weeks, and 4 weeks. In 3 others, amnionitis occurred. In these, sutures were removed and labor was induced with oxytocin. In all 3, the cervix was dilated over 3 cm. with bulging membranes at the time of cerclage. The membranes may have been instrumentally penetrated during the initial surgery.

HORMONE THERAPY

Delalutin, 250 mg. intramuscularly daily, was given to 22. Other hormones that were used were

Provera and Provest. Fifty-eight others did not receive hormones post-operatively.

INTERVAL BETWEEN SURGERY AND DELIVERY

The average duration of pregnancy before its termination following surgery in all groups was 12.6 weeks. The average gestational age at birth was 32.08 weeks. Gestational ages at birth following Shirodkar and McDonald operations were similar (Table 4). Except for group 1, newborn weights following McDonald's procedure were similar to those following a Shirodkar cerclage. Both technics have yielded similar results in preventing prematurity.

FETAL OUTCOME

Thirty-five of 90 pregnancies resulted in infants weighing over 2,500 grams. When compared with previous pregnancies (Table 3), the incidence of infants weighing over 2,500 grams increased by 26 percent. Average weight at birth for the whole group was 2,068 gm. Results have not been improved during the six years of the study (Table 5).

REMOVAL OF THE CERCLAGE

Forty-three (47.7%) had the cervical sutures removed because of spontaneous rupture of the membranes. Premature labor onset necessitated

TABLE V FETAL OUTCOME

Chronologi Groups	cal	2500	nt Birth Wei 1000 - 2500	ghts 1000	Average Weight
	40	(400/3		-	
!	12	(48%)	8	5	2270
11	- 11	(44%)	8	6	2015
111	9	(36%)	10	6	1990
IV	3	(20%)	10	2	1998
Total					
Average	35	(39.25%)	36 (40%)	19 (20.75%	2068.25

suture removal in 38. Sutures were removed five times before labor began. In 4 who were delivered by Caesarean section, sutures were not removed.

SUMMARY

Ninety cervical cerclages in 82 patients are reviewed. There was a 26 percent increase in the number of mature babies obtained when compared with previous pregnancies in the same women. There was a progressive increase in the

frequency of early operations during the study period. None whose cervix was more than 3 cm. dilated at the time of cervical cerclage had a viable infant.

Forty-eight percent had premature rupture of membranes after cerclage. Both technics yielded similar results.

Fetal loss from cervical incompetence may be reduced further by early diagnosis and careful attention to operative technic.

Suppression of premature labor with drugs (alcohol, isoxsuprene, progestogens) may decrease the incidence of premature labor following cerclage.

REFERENCES

- MacDonald, I. A. Suture of cervix for inevitable miscarriage. Journal of Obstetrics and Gynecology. Brit. Emp. 64:346:1957.
- 2. Shirodkar, V. N. A new method of operative treatment for habitual abortions in the second trimester of pregnancy. *Antiseptic*. 52:21:1955.

(Note: Many Michigan physicians, and some interested Michigan business firms contribute regularly to the AMA Education, Research Foundation to help medical schools, medical students and the AMA Biomedical Institute. Continued contributions are urged by MSMS officials and by the leaders of the Woman's Auxiliary which has been most active in Michigan in supporting the work of the AMA-ERF. A photo-feature about the AMA Biomedical Institute appeared in the August issue of *Michigan Medicine*.)

COMPARATIVE REPORT OF SOME OF THE SOURCES OF AMA-ERF FUNDS AND TOTAL DOLLARS RECEIVED FOR THE PERIOD FROM JANUARY 1 THROUGH JUNE 30 FOR 1968 AND 1969.*

FUNDS FOR AMA-ERF RECEIVED FROM PHYSICIANS (JANUARY THRU JUNE)

FUND	1968	1969
Medical Schools	126,422.51	114,623.99
Loan Guarantee	49,267.75	11,776.67
Unrestricted	54,703.32	63,871.32
Biomedical Institute	1,932.00	2,779.20
TOTAL DIRECT FROM PHYSICIANS TO AMA-ERF OFFICE	232,325.58	193,051.18

FUNDS FOR AMA-ERF RECEIVED FROM COUNTY, STATE AND OTHER MEDICAL SOCIETY TREASURIES. (JANUARY THRU JUNE)

FUND	1968	1969
Medical Schools	12,103.32	11,115.01
Loan Guarantee	10.00	00.00
Unrestricted	6,660.00	3,365.00
Biomedical Institute	95.00	260.00
TOTAL FROM COUNTY, STATE AND OTHER MEDICAL SOCIETY TREASURIES	18,868.32	14,740.01
WEDICAL SOCIETY TREASURIES	10,000.32	14,740.01

FUNDS FOR AMA-ERF RECEIVED FROM WOMAN'S AUXILIARY TO AMERICAN MEDICAL ASSOCIATION (JANUARY THRU JUNE)

FUND	1968	1969
Medical Schools Loan Guarantee Restricted (Esther Long Memorial Fund) Biomedical Institute	179,888.74 43,283.29 00.00 22,327.67	266,201.88 9,889.99 (3,817.00) 47,111.78
TOTAL FROM WOMAN'S AUXILIARY TO AMA	245,499.70	327,020.65
GRAND TOTALS	496,693.60	534,811.84

^{*}This report does not include AMA-ERF Funds received from other sources, such as Businesses, Industries, Other Foundations, etc.

An evaluation of the use of Thioridazine and its role in the total treatment program of a comprehensive, community-oriented and diversified psychiatric service is the subject of study. Changes in mental status, adjustment process and progress in rehabilitation of 50 patients are measured to determine the effectiveness of Thioridazine in the treatment of major psychiatric disorders.

The Use of Thioridazine In a Comprehensive Mental Health Program

BY AHMAD KAFI, M.D. DETROIT

INTRODUCTION

A recent development in mental health is the integration of community resources and hospital services to provide comprehensive care and continuous treatment for all gradations of mental illness. In 1964, a comprehensive mental health program of this kind was established* at the Ypsilanti State Hospital to serve the 200,000 residents of Washtenaw County, Michigan. The program is staffed by four phychiatrists, three social workers, three registered nurses, one occupational therapist, and 10 attendants who are aided by students from nearby universities, schools of social work, public health, nursing and occupational therapy. The patients cared for by the Unit are adult (17 years of age and older) and present with all types of mental illness. Approximately 20 patients are admitted each month either voluntarily or by court order. At present, there are facilities for 60 inpatients; approximately 40 outpatients are seen monthly at the Unit's clinics, and more than 200 are visited regularly by public health nurses for aftercare follow-up.

The Washtenaw County Unit provides a complete and unified range of services, including:

Preadmission evaluation and screening

Inpatient admission and intensive treatment

Twenty-four hour per day, 7-day per week emergency service

Partial hospitalization, including: Night hos-

pital care where patients work in the community during the day and return to the hospital each night and on weekends; Day hospital care where patients stay with their families overnight and on week-ends and visit the hospital during the day for treatment.

Rehabilitation programs

Aftercare programs, in which discharged patients visit hospital or community clinics or are visited by public health nurses and/or the Unit's staff.

Community workshops and placement service Family care homes

Welfare and nursing home placement

The forms of treatment utilized in this program are extensive and include individual and group psychotherapy, occupational and recreational therapy, industrial-vocational rehabilitation, convulsive therapy, and chemotherapy. This last modality has been particularly useful. In fact, the advent of psychotropic drugs, notably the phenothiazines, contributed in large part to the extension of psychiatric care from an isolated hospital setting to the community. An evaluation of one of these phenothiazines, thioridazine,* and its role in the total treatment program was undertaken within the framework of a study designed to determine the progress of 50 patients receiving intensive treatment.

MATERIALS AND METHODS

These patients constituted a random sample of patients who were placed on thioridazine by their treating physicians during a period of six months, irrespective of the projected study. The treating physicians and personnel were not involved in the study of these patients and the rater did not participate in the type of treatments they were receiving. Twenty-four of the patients were men and

The author was director of the Washtenaw County Unit of Ypsilanti State Hospital in Ypsilanti at the time this article was written. He is now an associate physician with the Department of Neurology and Psychology at Henry Ford Hospital.

^{*} Through a grant from the National Institute of Mental Health No. 1R11 MHO1713-01 and No. 5R20 MHO1713-03.

^{*} MELLARIL, Sandoz Pharmaceuticals

TABLE ! DIAGNOSES

		Number of patients
Schizophrenia		35
	17	
Paranoid type	15	
Other types	3	
Chronic Brain Syndrome with Psychosis		4
Affective Disorders		5
Character Disorders or Alcoholism		6
Total		50

26 women. Twenty-four were admitted on a voluntary basis and 26 on court order. Their ages ranged from 18 to 71. Their diagnosis is shown in (Table I).

The movement of these patients through various phases of the Unit's treatment program was followed carefully for six months. Progress toward rehabilitation, or discharge to the community, was considered a valid although simple method for rating the overall effect of this unit's treatment program. As a measure of individual response, changes in each patient's mental status and adjustment processes were also recorded. (Figures 1 and 2)

In addition to various milieu therapies, psychotherapy, and/or rehabilitative programs, each patient received thioridazine in a dose individualized for him according to the severity of his illness. This was adjusted for each patient to maintain optimal response and ranged from 50 to 800 mg. per day, with a median of 200 mg. per day.

RESULTS

Movement of the patients toward discharge (Figure 3) served as an overall index of the efficacy of treatment. Twenty-two of the 50 patients were discharged two months after treatment was initiated; within the subsequent four months, 24 more patients were discharged. Noteworthy also was the movement of patients from full-time to partial hospitalization. Prior to complete discharge, 17 patients were treated in the Night Hospital and 6 in the Day Hospital. Partial hospitalization enabled these patients to return gradually to normal activities by permitting them either to work in the community during the day or to participate in family life in the evenings and on weekends. This rehabilitation resulted from the patients' improvements in mental status and adjustment processes.

Change in mental status was reflected by the remission of symptoms listed in Figure 1. All but disorders of affect were substantially alleviated within three months. This symptom remitted more slowly and was still observed in nine patients after six months of treatment.

Figure 2 shows that good progress was obtained in five of six adjustment processes within three months. Heterosexual adjustment lagged, being obtained in one half of the patients (24 of 48) after six months.

These measures of improvement in mental status and adjustment processes influenced the patients' rehabilitations by affecting their attitudes toward their illness and need for treatment. Of the 46 discharged by the end of the study, 31 patients accepted aftercare (e.g. visits by public health nurses). (The remaining 15 either were not as-

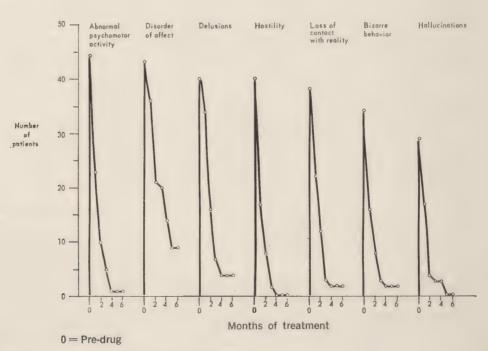


Figure 1. Progress in mental status

signed to such follow-up or refused it.) An improved attitude also apparently developed in seven patients (of 26) who were originally admitted by court order. Improved status during their course of treatment prompted them to request that they remain under the care of the Unit on a voluntary status.

DISCUSSION

A comprehensive mental health program aims to provide psychiatric care to all who need it, where they need it. To this end, it is designed to care for all gradations of mental disorder through all stages of illness. It provides full-time, inpatient care for the mentally disabled, partial hospitalization and outpatient care for rehabilitating patients, and follow-up services for those capable of complete return to the community. Such in-community services and programs also may be useful in forestalling the development of mental illness. If it can be detected and properly treated in its early stages, the number of initial hospitalizations may be reduced.

Experience at this comprehensive unit has demonstrated that chemotherapy is indispensable to the success of such a treatment program. This is in line with other investigators' findings that psychotropic drugs, notably the phenothiazines, are essential to patient welfare,2 such patients being better able to remain in the community without rehospitalization.3 Using thioridazine in discharged schizophrenics, Wright4 reported they were successfully maintained in the community and restored to functional capacities. More pertinent, however, is a recent report on a community mental health program similar to ours in which thioridazine was found to be "a major contribution to more effective management of the mentally ill."2

On the whole, patients in our program moved rapidly from total dependency as inpatients, through day or night hospitalization with partial community involvement, to full discharge to the community (Figure 3). This rehabilitation resulted from improvement in target symptoms (comprising "mental status") and attitudes ("adjustment processes") and may be attributed largely to our use of thioridazine. This drug attenuated patients' symptoms and, thereby, enhanced their response to the entire treatment program.

Thus, integration of the proper psychotropic drug into a comprehensive treatment program should bring significant benefits to the treatment and rehabilitation of mentally ill patients. Rapid remission of illness will return patients to the community and free much-needed inpatient facilities sooner. If proper and adequate medication is maintained, many readmissions will be prevented. Available hospital resources also may be more effectively utilized as patients achieving ambulant status require partial rather than full-time hospital care. Moreover, if illness is detected

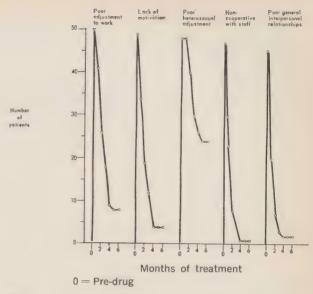


Figure 2. Progress in adjustment processes

in early stages, appropriate drug therapy may sustain the patient in the community without recourse to hospitalization. Thioridazine appears well suited to such community-oriented mental health programs. In addition to clinical efficacy, this drug offers a low incidence of adverse reactions. This benefit is significant since, with thioridazine, the course of a patient's rehabilitation is not threatened by the likelihood of serious side effects, such as extra-pyramidal reactions, which will only further complicate his adjustment.

SUMMARY

The function of a comprehensive mental health program is described. Over a period of six months, 46 of 50 patients progressed from full-time inpatient care to complete discharge. Thioridazine was shown to be a significant factor in a comprehensive-care and continuous-treatment program de-

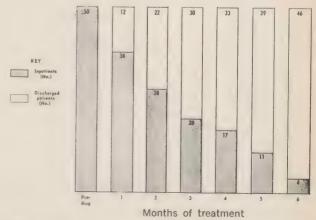


Figure 3. Progress in rehabilitation: discharge of patients

USE OF THIORIDAZINE/Continued

signed to restore patients to functional capacities in the community.

REFERENCES

- Kafi, A., Poole, D., Dukay, A.: Geographic Unit Provides Community Mental Health Services. Hospital and Community Psychiatry: 152-154, (May) 1968.
- 2. Manizade, A.: The county mental health center and
- its role in community psychiatry. Maryland State M. J. 16: 49-51, 1967.
- 3. Pasamanick, B., Scarpitti, F. R., Lefton, M., Dinitz, S., Werner, J. and McPheeters, H.: Home vs. hospital care for schizophrenics. J.A.M.A. 187: 177-181, (January) 1964.
- 4. Wright, G.: The treatment of non-hospitalized schizophrenics. Am. J. Psychiat. 119 (3): 261-262, 1962.

Rubella Vaccine for Michigan Children To Be Available in the Fall

JOHN L. ISBISTER, M.D. CHIEF, BUREAU OF COMMUNITY HEALTH MICHIGAN DEPARTMENT OF PUBLIC HEALTH

The State of Michigan is launching a rubella (German measles) immunization program to head off the damage that could be caused by the anticipated epidemic next year. In the epidemics of 1964 and 1965, thousands of babies whose mothers had German measles during pregnancy were born with serious birth defects.

The plan is to immunize children in the early elementary grades first. These are the children most susceptible, most accessible, and most likely to become infected. Immunizing this group first will significantly reduce the risk of pregnant women being exposed to the disease, since this group is the major source of spread of the virus.

At the urging of public health officials in Michigan, the 1969 Legislature appropriated \$750,000 for vaccine purchase before it recessed in July. This will provide about 600,000 doses of the vaccine, HPV-77 strain, which will be distributed to local health departments in single dose disposable syringes.

DISTRIBUTION NOTICE

Directors of local health departments throughout the state have been notified by the Michigan Department of Public Health that they will be receiving sufficient quantities of rubella vaccine to immunize the children in kindergarten through the third grade of all public and non-public schools in their jurisdictions. The local departments are being encouraged to conduct the immunization program through the schools or on a similar basis, although the decision in this matter rests with the local units. It is held likely that some departments may seek the aid of private physicians in their areas in the conduct of the program.

Shipments of vaccine will start coming to the state health department in late September. The entire quantity of 600,000 doses will have been received by the end of February, 1970 under terms of the current shipping schedule. The state's distribution process will be designed to meet local needs and be as fair as possible. Toward this end local departments have been requested to submit by

mid-September a plan showing how they propose to administer the rubella vaccine, during what months they plan to carry out the program, and the number of doses they will require.

Although outbreaks of German measles have been reported already from several areas in the state, it is expected that the peak of any epidemic would occur sometime late in the spring of 1970. Because of a probable initial short supply of the vaccine, the United States Public Health Service recommended that quantities available be directed toward the children in the early school grades. Since the principal hazard of the disease is for the unborn infant, this approach was considered to be the best method of controlling an epidemic and protecting young women of childbearing age. Michigan health officials settled upon the K-3 children as the group where they could quickly do the greatest good with the available vaccine.

RESERVATIONS NOTED

The only reservation imparted by the state is that rubella (Meruvax/MSD) vaccine should not be given within one month following the administration of another live virus vaccine, nor may the rubella (Meruvax/MSD) vaccine be followed by a live virus immunization within one month. It is also noted that a tuberculin test administered within one month after any live virus vaccine may yield a false negative result.

The Michigan program to immunize 600,000 children against rubella is merely the "opening gun" in a battle against the disease. In future years children entering school for the first time will be picked up in the immunization program. And as vaccine supplies grow it is hoped that older children (through puberty) will be immunized by their family physicians. As someone put it, the state is "buying time" until vaccine supplies can reach an adequate level for a routine immunization program to be effective.

It is expected that local health departments will shortly announce plans for administering the vaccine in their respective areas.

Doctor Dorsey Takes "Solipsistic" View of History

BY THOMAS J. HELDT, M.D. DIRECTOR EMERITUS DIVISION OF NEUROPSYCHIATRY HENRY FORD HOSPITAL, DETROIT

American Government. Conscious Self-Sovereignty by Dr. John M. Dorsey, Detroit, Michigan. Published by Center for Health Education. 1969. pp. 137. \$4.95.

Personal identity and individuality is the basic principle developed by Dorsey in this book. His every thought and declaration is supported by quotations from the most renowned and revered statesmen and writers of the world.

In his chapter on "American Citizenship in the Making," Dorsey sets down the fundamentals which constitute personal identity and individuality. He precisely develops the growth of a citizen of the United States. The efforts of such citizens make up the American Government of the people, for the people, and by the people.

From Dorsey's many pertinent declarations, I quote the following:

"Whenever careful study of the facts concerning an individual mind is made, the resulting finding is that these facts always perfectly justify the nature and needs of that mind and sufficiently explicate the conduct of that mind. Work in terms of the individual only, always reveals his mind to be 'normally' developed, 'normally' healthful, and 'normally' functioning. Certainly such self knowledge regarding the basic nature of a law maker is essential for every governmental officer beginning with the peace making policeman." (p. 26)

"Reading my Thomas Paine frequently turns out to be an exercise in clear observation of political theory:

'Almost everything appertaining to the circumstances of a nation has been absorbed and confounded under the general and mysterious word government. Though it avoids taking to its account the errors it commits and the mischiefs it occasions, it fails not to arrogate to itself whatever has the appearance of prosperity. It robs industry of its honors by pedantically making itself the cause of its effects; and purloins from the general character of man the merits that

appertain to him as a social being." (p. 27)

"Nineteenth century French political scientist Frederic Bastiat (The Law, Irvington, New York, Foundation for Economic Education) quite as would his fellow citizen Destutt de Tracy before him, could regard the making of his ideal citizenship in terms of the most orderly expression of his human constitution: 'Life, liberty, and property do not exist because men have made laws. On the contrary, it was the fact that life, liberty, and property existed beforehand that caused men to make laws in the first place.' And, 'See if the law benefits one citizen at the expense of another by doing what the citizen himself cannot do without committing a crime.'" (p. 34) . . . "Self vision or self violence is the law of human individuality. Therefore some explication of the free and brave functioning of human violence is in order. Aristotle clarified, 'He should know how to govern like a free man, and how to obey like a free man.'" (p. 37)

"Although my Kerner report (my abridged U.S. Riot Commission Report) contains reference to human individuality, it understandably orients itself largely as follows:

'The record before this Commission reveals that the causes of your racial disorders are imbedded in a massive tangle of issues and circumstances — social, economic, political, and psychological — which arise out of the historical pattern of Negro-white relations in America.'"

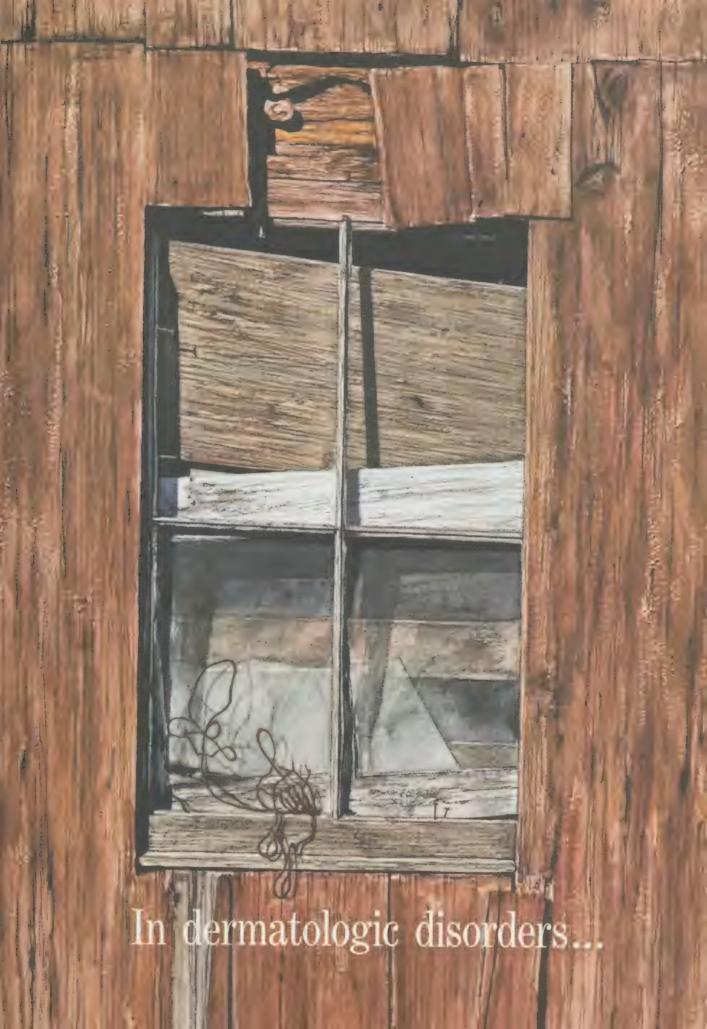
"In due detail the report illustrates the force of individual helpfulness also by recording Booker T. Washington's insightful view of toilsome self development for life appreciation: 'Self-help and self-respect appear in a practical and sure, if gradual, way of ultimately achieving racial equality. Washington's doctrines also gained support because they appealed to race pride—if Negroes believed in themselves, stood together, and supported each other, they would be able to shape their destinies.'"

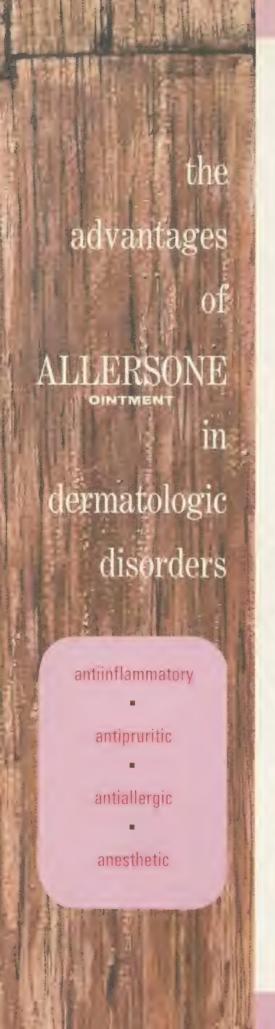
"I remind myself of Plato's philosophy of steadfast devotion 'to those things in which God abides and in beholding which' the mind conscious one 'for what he is.'" (p. 40)

Dorsey's ideology is solipsistic and is presented after the manner of an existentialist psychiatrist.

Dorsey closes his final chapter, Summary Review, with the words by Thomas Jefferson to James Monroe on April 15, 1785: (p. 131)

"My God! How little do my country men know what precious blessings they are in possession of and which no other people on earth enjoy."





IN THE MANAGEMENT of common dermatologic disorders, ALLERSONE provides more than symptomatic relief for your frustrated patient. Because ALLERSONE combines the antiinflammatory, antiallergic and antipruritic action of hydrocortisone with the anesthetic effect of diperodon HCl, it can make a worthwhile contribution to your therapeutic regimen.

ALLERSONE has long provided safe, effective and economical therapy for the anxious patient plagued by dermatologic problems. In addition, it is greaseless, odorless, colorless, as well as washable; thereby assuring a high degree of cosmetic acceptance.

ALLERSONE

OINTMENT

for effective topical management

COMPOSITION: Representing: Hydrocortisone 0.5%; Diperodon Hydrochloride 0.5%; Calamine 2.5%; Zinc Oxide 2.5% in a water-washable base containing sodium lauryl sulfate, propylene glycol, cetyl alcohol, white petrolatum, methylparaben and propylparaben as preservatives and water.

INDICATIONS: Antiinflammatory, antipruritic, and antiallergic preparation with local anesthetic for use in the treatment of atopic dermatitis, dermatitis venenata or contact dermatitis as ivy or oak poisoning, pruritis ani and vulvae (anogenital pruritus), certain allergic skin diseases as infantile eczema, also chronic eczematoid otitis externa, neurodermatitides, intertigo, as chafing of opposing skin surfaces as on thighs, axilla and below breasts.

ACTION: Hydrocortisone exhibits marked antiinflammatory activity when applied topically to the skin. It is ameliorative in pruritic, allergic and atopic skin lesions. Diperodon hydrochloride is a surface anesthetic, while the calamine and zinc oxide powders are well-known for their mild astringent and protective actions. The remaining ingredients comprise the water-washable base.

DOSAGE AND ADMINISTRATION: Distribute a small amount by gentle application over affected area, two or three times a day; frequency of application to be reduced with improvement.

CONTRAINDICATIONS: Do not apply in the presence of herpes simplex of the eye, chickenpox or other viral diseases or skin tuberculosis; in the presence of a coexisting bacterial infection, an antibacterial agent should be used concurrently.

PRECAUTIONS: In rare instances local sensitivity reactions might occur. The safety of the use of topical steroid preparations during pregnancy has not been fully established. Therefore, they should not be used extensively on pregnant patients, in large amounts or for prolonged periods of time.

ADVANTAGES: Contains a local anesthetic which quickly ameliorates pain —while hydrocortisone reduces inflammation—in a water-washable vehicle —no desquamation from fats.

CAUTION: Federal law prohibits dispensing without prescription.

HOW SUPPLIED: 0.90 Allersone, pink ointment, available in 15 Gm. tubes and in pound jars.



JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B - bacitracin - neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating,

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ½ oz. with ophthalmic tip. Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



Because peripheral vasodilation is needed now... and must often be continued

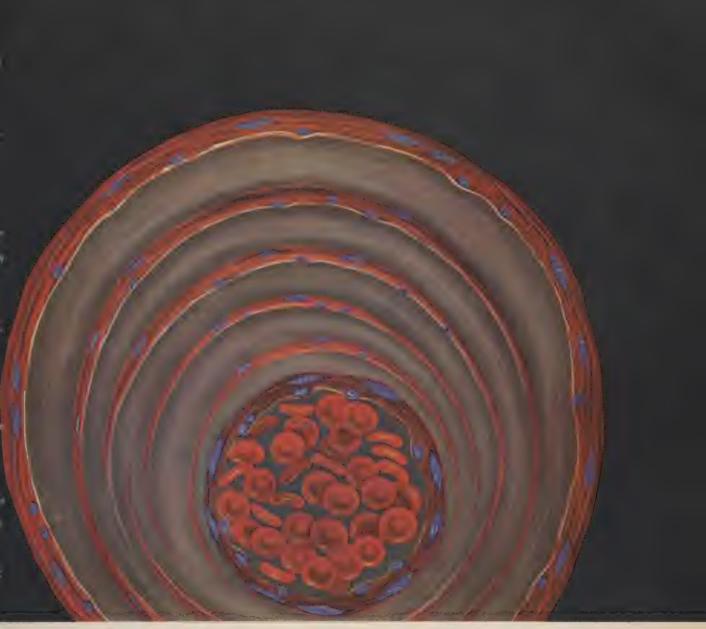
Roniacol Timespan (nicotinyl alcohol tartrate) can make a significant contribution to effective treatment of peripheral vascular disorders. It is directed specifically toward improvement of peripheral blood flow, relief of ischemic symptoms, and the long-term management of these conditions.

Specific pharmacologic action—Roniacol (nicotinyl alcohol) acts selectively by relaxing smooth muscle of peripheral blood vessels. Onset of action is smooth and gradual, rarely causing severe-flushing.

Relative freedom from side effects—Side effects

that may occur occasionally with Roniacol seldom require discontinuation of therapy.

Prolonged, continuous drug release—Prolonged peripheral vasodilation is provided by sustained-release Roniacol Timespan (nicotinyl alcohol tartrate) Tablets. Part of the drug becomes available immediately, the remainder continuously over a period of up to 12 hours, and dilation of constricted peripheral vessels is usually maintained. Thus, with a single dose of medication, patients can enjoy the benefits of increased peripheral blood flow in ischemic extremities for up to 12 hours.



Smooth peripheral vasodilation from initial dosage...extended with simple, well-tolerated, b.i.d. dosage

The prolonged action of Roniacol Timespan (nicotinyl alcohol tartrate) together with its other benefits offer a therapeutically practical measure in the long-term management of peripheral vascular disease—advantages especially important for older patients.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Conditions associated with deficient circulation; e.g., peripheral vascular disease, vascular spasm, varicose ulcers, decubital ulcers, chilblains, Meniere's syndrome and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

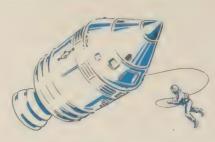
Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt—bottles of 50 and 500.

Roche

Division of Hoffmann - La Roche Inc. Nutley, New Jersey 07110

Art is a conception of peripheral vasodilation.



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate.

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.



WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals

Michigan Mediscene

Sept. 28-Oct. 2 – MICHIGAN STATE MEDICAL SOCIETY 104th ANNUAL SESSION, Sheraton-Cadillac Hotel, Detroit

Sept. 30-Oct. 2 — MSMS WOMAN'S AUXILIARY ANNUAL CONVENTION, Pontchartrain Hotel, Detroit

Oct. 1 — MD-PAC Breakfast, Sheraton-Cadillac Hotel, Detroit, 7:30 a.m.

Oct. 1 – MSMS COUNCIL, Sheraton-Cadillac Hotel, Detroit, 8:00 a.m.

Oct. 8-11 – 12th National Conference on Physicians and Schools, Pick-Congress Hotel, Chicago

Oct. 12 – AMA Midwestern Regional Conference on "Voluntary Health Agencies and American Medicine," Stouffer Hotel, Indianapolis

Oct. 19-25 – 7th Annual Community Health Week Oct. 22-23 – Joint meeting of Michigan T.B. Society and Michigan Thoracic Society, Kellogg Center, Michigan State University

Oct. 23 – 2nd ANNUAL SEX EDUCATION WORKSHOP, MSMS Headquarters, East Lan-

sing, All Day

Oct. 27 – American College of Emergency Physicians, MSMS Headquarters, East Lansing, 5:00 p.m.

Oct. 29 – 4th Diabetes Day, Genesee County Medical Society, Flint, All Day

Nov. 5 – MSMS COUNCIL, MSMS Headquarters, East Lansing, 9:30 a.m.

Nov. 9 – MICHIGAN STATE MEDICAL AS-SISTANTS SOCIETY, MSMS Headquarters, East Lansing, 11:00 a.m.

Nov. 19-21 – American College of Emergency Physicians Scientific Assembly, Denver, Colorado

Nov. 20 – Lansing Dietetic Association, MSMS Headquarters, East Lansing, 7:00 p.m.

Nov. 30-Dec. 3 – American Medical Association Clinical Convention, Denver

Dec. 1 – 9th Annual Thyroid Workshop, Wayne County Medical Society, Detroit

Dec. 15 – American College of Emergency Physicians, MSMS Headquarters, East Lansing, 5:00 p.m.

Dec. 10 – MSMS COUNCIL, MSMS Headquarters, East Lansing, 9:30 a.m.

April 12-16 - Michigan Nurses Week

April 30 — 1970 MSMS CONFERENCE ON MEDI-CAL ASPECTS OF MICHIGAN HIGH SCHOOL SPORTS, Towsley Center for Continuing Medical Education, The University of Michigan

May 10-16 - Michigan Hospital Week

MSMS to Help Citizens Obtain Medical Records In Suit Against State

Officials of MSMS have agreed to ask the cooperation of Michigan physicians in helping certain citizens obtain medical records from the years 1954 through 1966 which may entitle those citizens to share in a public settlement of \$100 million from the government.

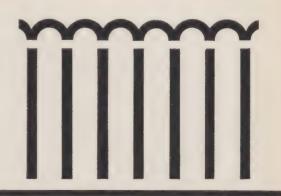
The help from MSMS was offered after the Detroit Free Press, through its "Action Line" citizen aid column, called and requested it.

"Physicians who are members of MSMS may expect a small number of requests from their patients for records in the coming months," responded Warren F. Tryloff, associate executive director. "We urge them to be responsible to these requests from their current patients and to the extent that they are able, to provide the information that will help the patients secure the proof required by the government."

The State of Michigan is one of many parties in a law suit charging several drug companies with violation of the price-fixing provision of the antitrust laws in the sale of certain antibiotic products during the period of 1954 through 1966. The broad spectrum drugs specifically are identified as aureomycin, terramycin and tetracycline products.

The drug companies involved have made a nationwide offer of \$100 million in settlement of the claims against them and worked out a plan for the members of the public who have purchased these products during the years involved to share in the settlement, if they can prove the dollar amount of the drugs they purchased.

Though the deadline was set at Aug. 16, 1969, the State of Michigan is still urging private citizens to file claims.



OUR STATE SOCIETY



single, non-narcotic preparation, it helps relieve pain . . .

norrhage [usually requires ea, vomiting and salicylate uced vomiting or gastric lavage, lyte therapy for ketoacidosis ervation for

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, anthistamine and possibly hydrocortisone. A few cases of leukopenia, usuelly transient, have been reported on continuous thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

ns section for management

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet

Wyeth Laboratories





Midsummer Meeting of July 31-Aug. 2

Extract of MSMS Council Minutes

GUBERNATORIAL APPOINT-MENTS — MSMS nominations for gubernatorial appoints to various boards, commissions and councils were discussed and recommendations were received from members of The Council.

councilors — The Chairman announced appointment of a committee to clarify the duties and responsibilities of Councilors and also announced that an informational meeting between new Councilors and MSMS officers would be re-instituted, beginning immediately after the 1969 meeting of the House of Delegates.

DOCTOR HISCOE — The Council noted that the Michigan Hospital Association had invited D. Bonta Hiscoe, M.D., to serve on its Committee on Community Health Services for a one-year term.

PROPERTY — The Council received word that MSMS had been successful in acquiring the property adjoining the MSMS head-quarters. The funds used for the purchase came from the Capital Reserve Fund, as authorized by The Council at its previous meeting.

ORGANIZATION — Proposal from a management consulting firm for organizational studies to increase MSMS efficiency was reviewed by the Advisory Committee to the Executive Director and recommended to The Council. The Council, because it had no

time to digest the report's recommendations for a study, postponed action on the report until the September meeting.

BUDGET — Upon recommendation of the Finance Committee, The Council approved budget amendments at the end of a sevenmonth period, to provide for certain reductions and increases in budget estimates for the balance of the year. The resulting excess of expenses over income amounts to just over \$25,000. It was pointed out that this excess of expenditure was primarily the result of a decline in advertising revenues of some \$22,000 and the emergency expenditures for the osteopathic medical school educational campaign of some \$14,000.

BLUE SHIELD — The Council adopted a report of the County Societies Committee regarding the composition and appointment of Regional Advisory Committees to Blue Shield. The Council Chairman was directed to communicate with component medical societies and Michigan Medical Service reporting this interpretation of 1968 Resolution 29.

MICHIGAN MEDICINE — The Council received mid-year reports on the operation of *Michigan Medicine* and, noting the decline in ad revenues, considered several ways of decreasing expenses.

INSURANCE — Important among the committee reports reviewed by The Council were the

minutes of the Committee on Professional Insurance Plans, which, upon recommendation of an outside insurance consultant, recommended that The Council reject the proposed Society-recommended liability insurance plan and in lieu thereof implement a recommendation that there be a Society-sponsored umbrella insurance plan for MSMS members.

committee renamed — Upon recommendation of the Committee on Maternal Health, The Council recommended to the Constitution and Bylaws Committee that the name of this Committee be changed to Committee on Maternal and Perinatal Health.

DISASTER CARE — The duties of the Committee on Disaster Medical Care were enlarged to include the problems of ambulance service.

MIDSUMMER SESSION — Reports from representatives of various health organizations who attended the Midsummer Session of The Council were received in a half-day session. Those organizations included the Michigan Department of Public Health, the University of Michigan Medical School, Michigan State University College of Human Medicine, the Michigan Association for Regional Medical Programs, Michigan Medical Service, Michigan Hospital Service, Michigan Department of Social Services, Michigan Health Council, and the Michigan Hospital Association.



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least nine specific differences in-

volving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to stay strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.





"What Is Your Question?" Brings Responses on Medicare, Medicaid

MSMS has had some responses to its newlyinaugurated "What Is Your Question" feature regarding the policies, procedures and difficulties of the Medicare and Medicaid health care plans.

If sufficient inquiries are received it is hoped other medical programs and subjects can be included for response by MSMS staff.

Following are two questions received at MSMS headquarters, followed by answers and a blank to be filled out and mailed to MSMS headquarters by any doctors who want to take advantage of the new service.

- Q. How do we resolve disputes with MMS on Medicaid?
- A. Essentially, disputes on Medicaid would be resolved in the same manner as for Medicare. If a doctor feels that further review is necessary, he should submit a "status inquiry" giving additional information and reasons for his inquiry. Unusual or complicated medical circumstances not previously reported should be included for review by MMS medical staff. If there is still a disagreement, the doctor has recourse through appropriate medical committees. The aforementioned information

is contained in Michigan Blue Shield's Physicians' Manual (Section VIII, pages 7-13).

- Q. Will Medicare alone (without Blue Cross) pay for X-rays plus EKG's **before** the \$50 deductible is paid?
- A. As of April 1, 1968 medical insurance pays for the full reasonable charges of physicians performing radiology and pathology services for hospital inpatients if the hospital is participating or meets basic conditions of participaton. No part of the charges for these services can be applied to the \$50 annual deductible. EKG's are not covered under these provisions whereas X-rays are. Therefore, the \$50 deductible is applicable to EKG's. The \$50 annual deductible is applicable to all covered physician services on an outpatient basis or in a doctor's office to include X-ray and pathology. This information is contained in Social Security Administration publication: "Your Medicare Handbook" (SSI-50, page 17) and "Medicare - A Reference Guide for Physicians" (SSI-51, pages 17, 18 and 19).

Mail to	: Medicare, Medicaid Question Department c/o Michigan State Medical Society 120 W. Saginaw East Lansing, Michigan 48823
My que	stion is:
	Name
	Address

PLAINWELL SANITARIUM, INC.

Plainwell, Michigan — MU 5-8441

M. Leroy Barry, M.D.

Dan W. Everett, M.D. Wilbur R. King, Ph.D.

The Plainwell Sanitarium is a private psychiatric hospital licensed by the Michigan Department of Mental Health, and member of the American Hospital Association, Michigan Hospital Association, and National Association of Private Psychiatric Hospitals. Our extensive diagnostic treatment services include the following:

- Organic and psychological therapy for the psychiatrically and emotionally disturbed of all ages.
- Diagnostic evaluation of neurological disorders.
- Rehabilitative services for geriatric and convalescent patients.
- Medico-Legal counsel.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for Probate and Juvenile Courts.

Each month specially designated pages in MICHIGAN MEDICINE will be devoted to information news briefs concerning items for your interest and knowledge about government medical programs. Those articles will briefly detail the latest pertinent changes, views and activities in order to provide information to our membership about these vital programs as they affect the medical profession.

The Committee on Governmental Medical Care Programs hopes that you direct your attention to this section and invites your comments and suggestions. Limitations on space prevent a comprehensive review of these many programs. If you are interested in a more detailed analysis please write MSMS.

Robert E. Rice, M.D., Chairman Committee on Government Medical Care Programs

MEDICAID

P.L. 91-56 (H.R. 5833) was signed into law on August 9, 1969. This bill extends the deadline for states to provide comprehensive care from 1975 to 1977. It clarifies "aid or assistance" as it relates to deductions in State expenditures to mean money payments to public aid recipients and permits a state to modify its Title 19 plan if the Governor certifies that the amount of state funds expended will not be less than the amount expended previously and if the modification of the state plan is not being made for the purpose of increasing the federal matching funds. The existing law contained a provision that would deny states federal funds unless it made a satisfactory showing that the scope of care and services available under Medicaid would result by July 1, 1975, in the furnishing of comprehensive care and services to substantially all individuals who meet the state plans eligibility standards with respect to income and resources. This amendment would have the effect of delaying that requirement for two

(Source: AMA Legislative Roundup, August 15, 1969)

MEDICARE

Summary recommendations of the Health Insurance Benefits Advisory Council (HIBAC) have been released by HEW Secretary Finch and transmitted to the Congress.

The HIBAC is composed of representatives of associations and organizations in the field of medicine, experts on the delivery of the financing of health care, and representatives of business, labor, consumers, and the general public.

In brief, the recommendations are:

I. After consultations with professional groups, the Secretary (HEW) would propose legislation which would discontinue reimbursement for services of a physician's supplier where there



GOVERNMENTAL-MEDICAL CARE PROGRAMS

is evidence of fraud; repeated overcharging of the program or its beneficiaries; a pattern of rendered services substantially in excess of those justified by sound medical practice; persistent failure to cooperate with the program in clarifying cases which may involve excessive services or charges; or documented rendering of services or supplies which were harmful to the beneficiaries or found to be grossly inferior by peer review.

2. To develop feasible and desirable standards of eligibility for the rendering of various types

of medical services by physicians under the Medicare program and the administrative procedures necessary for enforcement.

- 3. To establish legislation removing the present limitation on the HEW Secretary's authority to establish health and safety standards for hospitals, so that he has authority to establish health and safety standards for hospitals commensurate with his authority to establish such standards for other providers of services and for independent laboratories.
- 4. To establish legislation authorizing the Secretary to arrange with State agencies to survey accredited facilities at intervals between accreditation surveys and when deficiencies are found and to transmit this information to the accrediting agency, report to the Secretary and make recommendations with respect to certifications.

Other recommendations included: establishing legislative authority to develop and apply standards for Medicare covered ambulance services; placing all home health benefits under Part A with maximum eligibility for 200 visits per year; removing the 3-day hospital stay requirement for home health benefits; providing for co-insurance for the second 100 visits per year; establishing utilization review of home health services to become effective one year after issued regulations; generally excluding immunization coverage under Medicare; eliminating blood deductibility; allowing participation of community mental health centers in the Medicare program; removing the 190-Day lifetime limit on in-patient psychiatric hospital benefits if a review of past experience shows such removal would significantly increase health benefits in relation to costs involved; broadening incentive experiments so that Medicare, Medicaid, and Maternal and Child Health programs could also participate to achieve greater economy and efficiency; authorizing the Secretary to negotiate capitation reimbursement payments to group practice pre-payment plans.

(Source: HEW News Release, July 27, 1969)

. . . .

Blue Cross has disbursed \$428 million in Medicare benefits for Michigan beneficiaries in the first three years of the program. Approximately 800,000 Michigan residents are eligible for Medicare and the total benefits paid averaged \$525 per beneficiary. Michigan Blue Cross, as fiscal intermediary for the Medicare program, handles bills for inpatient hospital services, home health visits, and extended care. (Source: Michigan Blue Cross, 7-1-69)

* * *

The staff of the U.S. Senate Finance Committee recently released data disclosing that Medicare's

Hospital Insurance Trust Fund will be exhausted in 1976, and the Supplementary Insurance Trust Fund will show a deficit of \$351 million by June, 1970.

According to the staff report the financial plight stems from a more rapid increase in hospital costs and physicians' fees than the original estimates assumed, from intermediary and carrier costs that have exceeded original budgets, from lax intermediary and carrier performance and ineffective utilization review.

To remedy the situation it was recommended that Hospital Insurance Tax be increased 20 percent, the deductible be increased from \$44 to \$175, or cost control be improved, or some combination of these alternatives be effected.

To make this Supplementary Medical Insurance actuarially sound, it was recommended to increase the monthly premium from four dollars to \$4.40, to increase the deductibility from \$50 to \$80 or to improve cost controls or effect a combination of these alternatives. (Source: Prentice-Hall Report Bulletin No. 3, July 90, 1969)

IMMUNIZATION BY PUBLIC HEALTH NURSES

Act 191, P.A. 1969, amends Section 4 of Act 164, P.A. of 1949, so that public health nurses employed by the health department ". . . may be authorized by the health office or the health department to give immunization treatment provided they shall do so under the direction of a duly registered and licensed physician." This act was ordered to take immediate effect.

Through this amendment of Act 164, it is no longer necessary for the physician to be present at the scene where health department nurses are administering immunization. (Source: The Circular, Michigan Department of Public Health, Aug. 22, 1969, Vol. 31, No. 16.

FIRST INDIAN COMMUNITY ACTION AGENCY AUTHORIZED

Governor William G. Milliken on May 21, 1969 approved an Office of Economic Opportunity grant of \$50,000 to the Inter-Tribal Council of Michigan to develop programs to provide employment and health services, adequate housing, counseling services, vocational training services, and other programs.

The Council incorporated in 1968 to unite reservation Indians in Michigan and the grant will serve a potential 3,500 reservation and reservation-connected Indians.

(Source: Michigan OEO Newsletter Vol. 5, No. 6.)



Let's be specific about Campbell's Soups... and reducing diets



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to: Campbell Soup Company, Box 265, Camden, N. J. 08101



Pro-Banthine Helps... propantheline bromide

...REVEAL the ulcer

...HEAL the ulcer

The efficiency of Pro-Banthīne—its favorable balance of therapeutic and secondary actions—has been thoroughly tested and observed. This quality has been demonstrated surgically, roentgenographically, cinegastroscopically and, above all, clinically.

When physicians needed to relax the restless duodenum for the recently refined technic of hypotonic duodenography they logically turned to Pro-Banthīne.

For years Pro-Banthīne has been the most widely used anticholinergic medication for calming the gastrointestinal tract—for suppressing secretion, prolonging the action of antacids and providing the proper environment for healing peptic ulcers.

These established therapeutic actions make Pro-Banthīne particularly useful in:

- peptic ulcer
- gastritis
- diverticulitis
- irritable colon
 - biliary dyskinesia
 - functional hypermotility

We wish to thank Drs. Marcia K. Bilbao, Louis H. Frische, Josef Rösch and Charles T. Dotter for this exceptionally graphic example of hypotonic duodenography.

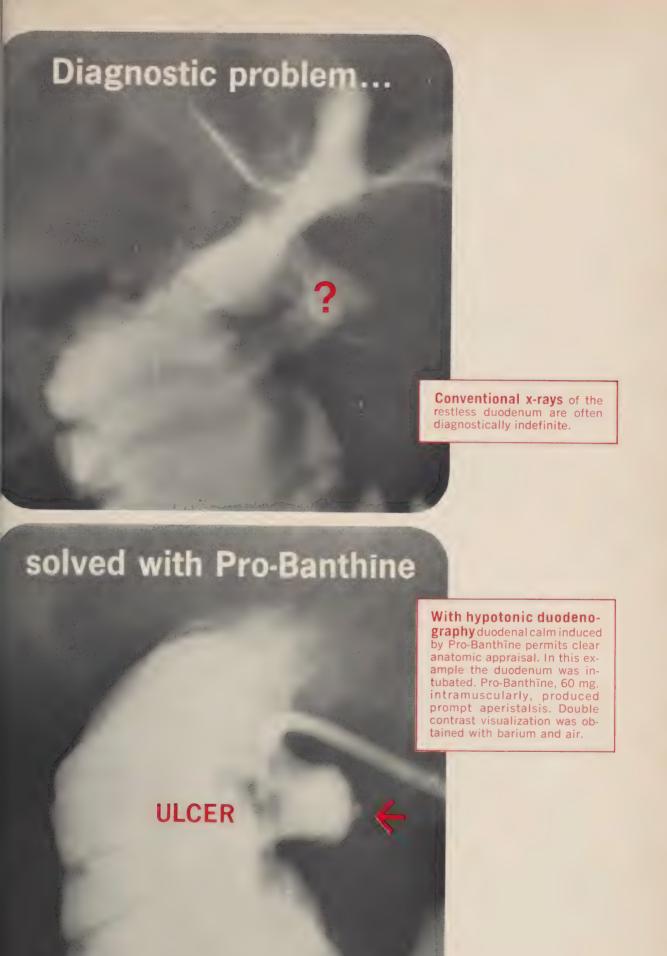
Contraindications: Glaucoma, severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly men with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal dosage tolerated without excessive side effects is usually the most effective. For most adult patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two 15-mg. tablets four to six times daily may be required. Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.





What's Polycillin (ampicillin) got to do with the price of bananas?

Just this: According to the U.S. Bureau of Labor Statistics, bananas are one of the few things that actually cost less today than five years ago. The same is true of Polycillin. In fact, the price of Polycillin has been reduced about 30% since its introduction in 1963...making it, according to national surveys of patient costs, as economical as leading brands of tetracycline and erythromycin.

And Polycillin is available in a variety of dosage forms for your patients—more than any other ampicillin. It comes in 250 mg. and 500 mg. capsules; in convenient, chewable tablets of 125 mg; oral suspension, 125 mg. and 250 mg. per 5 ml.; and in pediatric drops, 100 mg. per ml. Also available parenterally as Polycillin-N (sodium ampicillin).

BRISTOL LABORATORIES
Division of Bristol-Myers Co
Syracuse, New York 13201



Michigan Doctors Serve as College Trustees

A growing number of medical doctors from around the state serve their regions as trustees of two-year community colleges. In that capacity they join with college administrators and townspeople to help attract the best faculties, provide centers of learning for surrounding communities, make the educational process relevant to students and battle millage campaigns. The men pictured on this page are representative of those from the medical profession who take on a double challenge of service by becoming community college trustees. Other doctors serve on the boards of control of four-year colleges and universities in Michigan.

IN OFFICIAL CEREMONIES in July, 1968, Clarence B. Kimbrough, M.D., right, became the first Negro to be installed as president of the Flint Board of Education. His term of office up, he now serves as a board member. He was elected to a six-year term in April, 1967, leading the field of six candidates with a total of 12,920 votes. Doctor Kimbrough is vice chief of staff at Hurley Hospital, Flint, and has been in private practice for 16 years.

STORY IN BLUEPRINT is studied by Warren W. Cline, M.D., left, and Harry Weitz, M.D., members of the Board of Trustees of Northwestern Michigan College in Traverse City. Both have been active in all phases of the school's current expansion program. Doctor Cline, an internist, was unopposed for re-election to his second six-year term in November, and Doctor Weitz, chief of radiology at Munson Medical Center, Traverse City, was elected to his second full term in 1966.



CHAIRMAN OF THE BOARD of Muskegon County Community College is Robert J. Fles, M.D., who has good cause for admiring the handsome new college buildings mirrored in the creek which flows diagonally through campus. Doctor Fles has been a board member six years including the time the three-year-old, \$6 million college was built. He continues as head of the board of the 4,000-student college until January, 1970.





MSMS PAST PRESIDENT William S. Jones, Sr., M.D., Menominee, center, visits with two doctors attending the 1949 Annual Session. They are seated at the entrance to the exhibition hall in Grand Rapids, site of that annual scientific meeting.



1964 BIDDLE LECTURER at the MSMS Annual State Society Dinner Dance was U. S. Congressman Gerald Ford, who was photographed addressing the crowd. Oliver B. McGillicuddy, M.D., Lansing, was installed as MSMS president that year.



UNVEILING THE MARKER commemorating the site of the Michigan State Medical Society's organizational meeting nearly 100 years earlier was a big event of Sept. 19, 1965. The society, with 100 physicians present from all sections of Michigan, first met on June 15, 1866, in the Supreme Court Room of the Odd Fellows Hall, which was subsequently torn down. The marker stands in a small Detroit city park on the west side of Woodward between Congress and Larned.

Remember When?

STATE SOCIETY OFFICERS each year in the past took a good-will swing through the Upper Peninsula, and on one of them L. Fernald Foster, M.D., Bay City, became an honorary fire chief of Manistique. Doctor Foster, who was for many years the secretary of MSMS, was a well-known fire truck and fire station buff, and delightedly wore his fire chief's hat in this 1951 photo. Flanking him were Manistique's real Fire Chief Elmer Boals, left, and other city fathers, including Mayor James H. Fyvie, M.D., at right of Doctor Foster.





"Defense of Life" is the title of this exhibit developed by The Upjohn Company, Kalamazoo, for display at the recent annual AMA convention. The giant model of blood vessels shows a pin-head sized patch of human tissue, magnified 25,000 times. The exhibit demonstrates how blood cells and chemical enzymes are brought into play within the blood vessels when the body mobilizes its defenses against injury or disease. The model is the latest in an Upjohn series to dramatize human biological processes for the benefit of the physician and the public.



HIGH PHYSICIAN PARTICIPATION characterizes the South Central Michigan Health Planning Council. Representing the Calhoun, Kalamazoo and St. Joseph Medical Societies, as well as surrounding public health departments and mental health service boards, they total 13 members. The doctors serve on the council's board and several committees, and are commended by Executive Director Paul E. Nelson for their "high degree of involvement and commitment to areawide comprehensive health planning." At a recent meeting, Byron Brown, M.D., public health officer for Barry-Eaton Counties, stands to make a point, while, seated at far right at head table, are William G. Birch, M.D., (light suit) president-elect of the health planning council, and Robert Leitch, M.D., immediate past president.

Unique Teaching Methods Employed at MSU's College of Human Medicine

TELEVISION EQUIPMENT RECORDS as a MSU medical student interviews a "simulated patient," an actress who has been coached to portray a specific set of symptoms and personality characteristics. The purpose is to teach beginning medical students to be sensitive to patients. After the interview, the tape is played back for discussion by the student, his classmates and the instructor.





MICHIGAN STATE UNIVERSITY medical students Thomas F. Alguire, left, of Flint, and Donald C. Parker of Adrian work in the pathology laboratory at St. Lawrence Hospital, Lansing, during a summer externship arranged by MSU's College of Human Medicine. Supervising is Joseph R. Cipparone, M.D., laboratory director.

HUMAN BIOLOGY AND BEHAVIOR laboratories at MSU contain individual units for each student. Each unit serves as a laboratory bench, a desk and a self-learning carrel. From left are medical students Theresa A. Baker of Wayne, Laurence A. Eidt of Bay City and Leonard G. Dorey of Pontiac.







if cough serves no useful purpose

RX Tussionex®

(Resm commences of Mydrocodone and Phenylloloxamine)

usually for 10 to 12 hours*)

TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.

Class B narcotic - oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

*DOSAGE: Adults: 1 teaspoonful (5 cc.) or tablet every 8-12 hours. Children: Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division Wallace & Tiernan Inc., Rochester, N. Y. 14623

His heart tells him he's an invalid

Anxiety is expected in the cardiovascular patient, little may even be desirable.

alliovascular symptoms, your help may ut when anxiety is exaggerated . . . when it erferes with sleep . . . when it aggravates

nd tension specifically, yet gently. aturally, you'll want to reassure the patient. nd perhaps prescribe Equanil (meprobamate) adjunctive therapy. It helps relieve anxiety

ide effects are rare. owsiness; serious, therapy-interrupting de effects are generally limited to transient lmost 15 years' use has shown that Equanil usually well tolerated as well as effective.

History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with judgment and coordination.

or dangerous machinery. Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles.

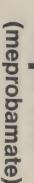
Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are are, but such reactions, sometimes severe, can develop in patients contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, eachymoses, peripheral edema and fever have been reported. One fatal case of bullous prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis,

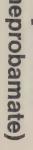
Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern, Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.). Doses above 2400 mg./day are not recommended. stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocordisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

packJ, Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg. , 200 mg. and 400 mg. meprobamate. EALS® EQUANIL (meprobamate) so available in REDIPAK® [strip

Wyeth Laboratories Philadelphia, Pa.

Equa











Terramycin[®] (oxytetracycline)

An infection of rapid onset requiring prompt attention. Teenage girl with chills, fever, abdominal pain, backache and nausea. Frequent and urgent urination with burning. On examination—tenderness over kidney. Blood count and urinalysis confirm the diagnosis: acute pyelonephritis. Treatment is initiated with Terramycin. Within a few days of follow-up therapy, the patient is markedly improved. The pretreatment urine culture shows a strain of *E. coli* highly susceptible to Terramycin.

Experience has shown that Terramycin offers special advantages in treating urinary tract infections when strains of causative bacteria are susceptible.

Broad-spectrum coverage unaffected by penicillinase. Effective tissue levels to help reach foci of infection in renal parenchyma. High urine levels—excreted by kidney in active form.

With Terramycin, you have the assurance that comes with choosing an agent physicians have depended on for over 18 years. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Contraindicated: In individuals hypersensitive to oxytetracycline.

Warnings: Reduce usual oral dosage and consider antibiotic serum level determinations in patients with impaired renal function.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight; if such reactions occur, discontinue therapy.

Note: With oxytetracycline, phototoxicity is unknown and photoallergy very rare.

Precautions: Use of broad-spectrum antibiotics occabilly may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy. Increased intracranial pressure in infants is a possibility. Symptoms disappear upon discontinuation of therapy.

Adverse Reactions: Nausea, diarrhea, glossitis, stomatitis, proctitis, vaginitis and dermatitis, as well as reactions of an allergic nature, may occur but are rare.

Supply:* Terramycin Capsules: oxytetracycline HCl, 250 mg. and 125 mg. Terramycin Syrup: calcium oxytetracycline, 125 mg. per 5 cc. Terramycin Pediatric Drops: calcium oxytetracycline, 100 mg. per cc.

*All potencies listed are in terms of the standard, oxytetracycline.

More detailed professional information available on request.

Terramycin[®] (oxytetracycline)





Scientific Articles Printed to Date

Each month *Michigan Medicine* prints selected outstanding scientific articles. To date, the following papers (with month, page number and author following) have been published:

JANUARY

- Page 31, "Lower Lung Field Tuberculosis," by Ma. Zenaida Fernandez, M.D., Zamboanga City, The Philippines, and Edward G. Nedwicki, M.D., Allen Park.
- Page 36, "Use of Cholesterol Kits," by Kenneth R. Wilcox, M.D., (Reprint from New England Journal of Medicine, Vol. 279, No. 18).
- Page 37, "Mammography and Xeroradiography," by John N. Wolfe, M.D., Detroit.
- Page 39, "Early Management of Facial Nerve Trauma," by Roger Boles, M.D., Ann Arbor.
- Page 45, "Treatment of Hypercalcemia," by Joseph J. Weiss, M.D., and Jose Yanez, M.D., both of Eloise.
- Page 49, "More Drugs Mean More Problems in Managing Diabetes Mellitus," by John B. Bryan, M.D., F.A.C.P., Royal Oak.

FEBRUARY

- Page 119, "The Future of Private Practice: Salvation at the Grassroots;" by Lewis A. Miller, Stamford, Conn.
- Page 131, "Mouse Toxicity of Triple Vaccine (DTP) Mixed with Poliomyelitis Vaccine," R. Y. Gottshall, G. R. Anderson, E. A. Nelson and K. R. Wilcox, M.D., all of Lansing.
- Page 135, "Massive Intra-articular Injection of Methylprednisolone without Harmful Side Effect," by J. C. Breneman, M.D., Galesburg.

MARCH

Page 209, "Myocardial Infarction During Hyperthyroidism," by Robert C. Douglass, M.D., Southfield; Myer Teitelbaum, M.D., Detroit, and Gerald J. Aben, M.D., Southfield.

- Page 213, "Trichophyton Violaceum," by James
 D. Stroud, M.D.; Jules Altman, M.D., and Coleman Mopper, M.D., all of Detroit.
- Page 215, "Psychiatric Referral of a Pediatric Patient," by Joan R. Chodorkoff, Ph.D., and Bernard Chodorkoff, M.D., Ph.D., both of Detroit.
- Page 217, "Development of a Program of Laryngoscopy, Therapeutic Bronchoscopy and Endobronchial Blocking Techniques: A Progress Report," by Martin L. Norton, M.D., F.A.C.C.P., Detroit.
- Page 220, "Accidental Poisoning, Where Do We Go From Here?" by George M. Lowrey, M.D.
- Page 221, "Diabetes and Pregnancy Preliminary Report," by Nancy T. Caputo, M.D., and Agna N. Pineda, M.D., both of Detroit.
- Page 223, "The Electrophoresis of Lipoproteins," by John G. Batsakis, M.D., and Martha M. Thiessen, M.S. (ASCP), both of Ann Arbor.

APRIL

- Page 341, "Suprapubic Cystostomy In Gynecologic Surgery," by Morton R. Lazar, M.D., F.A.C.S., F.A.C.O.G., and Eugene A. Snider, M.D., both of Detroit.
- Page 345, "Rhabdomyosarcoma: Report of 20 Cases," by Lawrence S. Bizer, M.D., Detroit.
- Page 349, "Psychiatric Referrals In A General Hospital," by Wiecher H. Van Houten, M.D., Ann Arbor.
- Page 353, "The Sinai Hospital Low Vision Clinic," by Morris J. Mintz, M.D., Ernest M. Gaynes, O.D., and Arnold H. Gordon, O.D., all of Detroit.
- Page 357, "The Physician and Differential Diagnosis of Communicative Disorders in Children,"

by Gerald S. Light, M.D., and William Wolski, Ph.D., both of Flint.

MAY

The issue featured special Michigan Week articles by leaders in health care in Michigan.

JUNE

- Page 571, "An Emergency Air-Ground System for Newborn Infants with Emergency Distress Syndrome," by L. J. Arp, Ph.D., R. E. Dillon, Mary Tom Long, M.D., and C. L. Boatwright, M.D., all of Blacksburg, Va.
- Page 575, "Experience with Thyroid Malignancy in a Private Referral Laboratory," by Joel I. Hamburger, M.D., Southfield.
- Page 581, "A Diabetic Has A Stroke," by Richard D. Hohl, M.D., Detroit.
- Page 581, "Night Dose May Control Brittle Diabetic," by Jack A. Litwin, M.D., Detroit.

JULY

- Page 685, "Anterior Mediastinotomy As A Means of Diagnosing Bronchogenic Carcinoma," by S. Amjad Hussain, M.D., B.S., David Glow, M.D., and J. C. Rosenberg, M.D., all of Toledo, Ohio.
- Page 687, "Christmas Disease With Multiple Familial Occurrence," by Frank D. Johnson, M.D., Robert K. Rank, M.D., and Robert Straley, M.T., all of Mt. Pleasant.
- Page 691, "Phenylketonuria in Newborns," by K. Stanley Read, Ph.D., Lansing, Richard J. Allen, M.D., Ann Arbor, and Theresa B. Haddy, M.D., Lansing.

AUGUST

- Page 795, "The Michigan Rheumatic Fever Study: Clinical Characteristics of Children Attending MDPH-Sponsored Cardiac Field Clinics," by Walter G. Parker, M.D., M.P.H., Ann Arbor.
- Page 803, "Cardiac Views: Treatment of Shock Following Myocardial Infarction," by Jay N. Cohn, M.D., Washington, D.C.
- Page 807, "Rhino-Orbital-Gerebral Phycomycosis," by C. Kohler Champion, M.D., U.S. Army, Germany, and Tom M. Johnson, M.D., East Lansing.

SEPTEMBER

Page 887, "Child Abuse - Analysis of a Current Epidemic," by Marilyn Heins, M.D., Detroit.

- Page 893, "Meniere's Disease: Notes from the Michigan Association for Better Speech and Hearing," by Jordan C. Ringenberg, M.D., Grand Rapids, and George W. Fuller, Jr., East Lansing.
- Page 985, "Raptus: A Neglected Psychophysiological Phenomenon," by Gordon R. Forrer, M.D., Detroit.
- Page 899, "Anticipating Death from Cancer Physician and Patient Attitudes," by Ronald R. Koenig, A.C.S.W., Detroit.
- Page 907, "Minor Footnote to Michigan Medical History: The Lansing Strain of Poliomyelitis," by Richard D. Bates, M.D., F.A.C.P., Lansing.

MSMS Membership Holds; AMA Totals Slipping

A review of membership figures for MSMS and the AMA reveals the following:

- The AMA in 1960 had a reported 75.7 per cent of all physicians as members; and 68.8 per cent in 1969.
- MSMS during the 1960-61 year had 89.8 per cent of the Michigan physicians as members, and 88.4 per cent in 1968-69.



In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

LEDERLE LABORATORIES

A Division of American Cyanamid Company, Pearl River, N.Y.

MICHIGAN MEDICINE OCTOBER 1969 1067



FOR MODERATE TO SEVERE ANXIETY WITH COEXISTING DEPRESSION TRANQUILIZER-ANTIDEPRESSANT

Containing perphenazine and amitriptyline HCI

TRIAVIL®2-25: Each tablet contains 2 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL®4-25: Each tablet contains 4 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL®2-10: Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

TRIAVIL®4-10: Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; urinary retention; pregnancy; glaucoma. Do not give in combination with MAOI drugs because of possible potentiation that may even cause death. Allow at least 2 weeks between therapies. In such patients therapy with TRIAVIL should be initiated cautiously, with gradual increase in the dosage required to obtain a satisfactory response.

WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be potentiated.

PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

SIDE EFFECTS: Similar to those reported with either constituent alone.

Perphenazine: Should not be used indiscriminately. Use caution in patients with history of convulsive disorders or

severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; severe acute hypotension (of particular concern in patients with mitral insufficiency or pheochromocytoma); skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma. laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); grand mal convulsions; cerebral edema; altered cerebrospinal fluid proteins; polyphagia; paradoxical excitement; photophobia; skin pigmentation; failure of ejaculation; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia; significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol), atropine, heat, and phosphorous insecticides.

Amitriptyline: Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea; excitement; hypotension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, blurring of vision, urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

For more detailed information consult your Merck Sharp and Dohme representative or see the package circular.





ANCILLARY SECTION

State Health Council Urges Doubling Of Cigaret Tax

With the release of new figures on the numbers of cigarets smoked during the past year by the state's citizens, officials of the Michigan Health Council simultaneously have recommended that the Michigan tax on cigarets be raised from seven to 14 cents.

"Michigan is searching for more revenue for its schools, colleges and universities and for medical care and hospitalization costs," observes John A. Doherty, MHC executive director. "The raise in taxes would provide approximately \$75,000,000 in additional revenue and more importantly might provide the incentive for thousands of additional Michigan residents to quit smoking if they have to spend seven cents more to buy a package of cigarets."

The MHC's latest figures, covering the fiscal year ending June 30, 1969, reveal that Michigan smokers bought 14,182,162 more packages of cigarets and puffed 283,643,240 more cigarets than during the previous fiscal year. The Michigan Department of Treasury-Cigarette Tax Division showed an increase of .96 in cigaret tax collection, compared to a decrease of 0.5 percent nationally.

The annual per capita consumption of cigarets by Michigan's approximately 8,500,000 residents was 2,671 cigarets. The average Michigan resident 18 years of age or older smoked 4,260 cigarets last fiscal year, an increase of 9.4 percent over 1968.

National and regional figures show that in most cases the lower the cigaret tax rate the more cigarets smoked per capita.

AMA Reorganizes Departments, Appoints New Officials

The American Medical Association has created two new positions in its staff organization and reorganized departments to coincide with the new positions.

Richard S. Wilbur, M.D., of California has been appointed to the new post of Assistant Executive Vice President, effective Oct. 1. He will be the principal deputy of the Executive Vice President and will act as Executive Vice President in the absence of that official. Under his direction will be the Management Services Division, Health Service Division, Communications Division and Public Affairs Division.

The new capacity of Assistant Executive Vice President for Scientific Affairs is being filled temporarily by Hugh H. Hussey, M.D., AMA Director of the Scientific Activities Division. The Executive Vice President for Scientific Affairs will direct the Medical Education Division, the Scientific Activities Division and the Scientific Publications Division.

The General Counsel and his staff, the two assistants to the Executive Vice President and the Director of Budgets and Control will answer directly to the Executive Vice President.

Additional changes that are being made by the AMA are the transfer to the Communications Division of the Officers Services Department and Speakers Services Department, while the current editor of JAMA and director of the Scientific Publications Division will be succeeded Jan. 1, 1960, by a new man.

Doctor Hussey will take over as editor of JAMA and Scientific Publications Division Director at that date, succeeding the current editor, John Talbott, M.D. At that time Doctor Talbott will become editor emeritus.

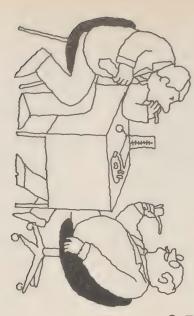
Doctor Berger New Director Of Maternal Health

Charles J. Berger, M.D., formerly of Southfield, is new Director of Maternal Health with the Michigan Department of Public Health. He succeeded Harold Ott, M.D., who resigned in July.

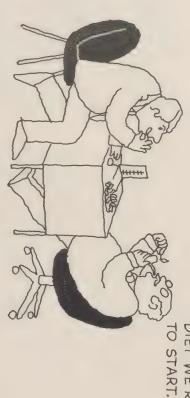
Doctor Berger has been an obstetrician-gynecologist in private practice in Southfield. He is a graduate of Wayne State University's School of Medicine and recently made a visit to Sweden to study that country's low maternal and perinatal death rates.

The Apprehensive Hypertensive

CUT OUT SMOKING-ALTOGETHER. BUT WE ARE GOING TO HAVE TO HIGH BLOOD PRESSURE. NOW CHANGE A FEW LIVING HABITS. MODERATE HYPERTENSION -WELL, YOU HAVE WHAT WE CALL DON'T WANT YOU TO WORRY, FIRST, WE'RE GOING TO HAVE TO



DIET WE'RE GOING LATER ABOUT THIS WE'LL TALK A LITTLE SHOULD DO IT ... 20 POUNDS THEN WE HAVE TO LOSE WEIGHT.



Regroton to lower blood pressure

chlorthalidone 50 mg. reserpine U.S.P. 0.25 mg.

nal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy*: Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women diately if abdominal pain, distention, nausea, vomiting, or gastrointesti Regroton®: chlorthalidone 50 mg., reserpine U.S.P. 0.25 mg. Indications: Hypertension. Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. Warning: With the administration of enteric-coated potassium ementation is not practical, the possibility of small-bowel lesions bstruction, hemorrhage, and perforation) should be kept in mind. urgery for these lesions has frequently been required and deaths have red. Discontinue coated potassium-containing formulations imme in fetal or neonatal jaundice, thrombocytopenia, and possibly which should be used only when adequate dietary supthe potential benefits of the drug should be ossible hazards to the fetus. Use of chlorthalidone

if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers. *Precautions:* Antihyperfensive therapy with this drug should always be initiated cautiously



AND CALM US DOWN. OUR BLOOD PRESSURE OR TENSE. AND WE'LL THAT MAKE US ANXIOUS TRY TO AVOID SITUATIONS PLENTY OF REST AND WE'VE GOT TO GET TAKE MEDICINE TO LOWER



and allay anxiety in hypertension

corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (billary colic may be precipitated). Bronchial asthma may occur in susceptible patients. Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglypenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, concemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorihalidone is combined with alcohol, barbiturates or narcotics, leukopenia, apiastic anemia, skin rashes, thrombocyto-

gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing anglitis are possible. <u>Average Dosage</u>: One tablet daily with breakfast. <u>Availability</u>: Pink, single-scored tablets in bottles of 100 and 1000.

nplete prescribing information

Regroto reserpine U.S.P. 0.25 mg. chlorthalidone

50 mg.

(Pig) Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

EVERY NINTH GRADER TO GET TB SKIN TEST

A program to give every ninth grader in the state a tuberculin skin test will be promoted during this school year by the Michigan Department of Public Health, the Department of Education and the Michigan Tuberculosis and Respiratory Disease Association.

It is anticipated that the program will provide a reliable state index of tuberculosis infection in this age group and also serve as a guide line for future tuberculin testing programs in the schools. Local health departments will be encouraged to arrange the tests for all ninth graders located in their area.

For uniformity, use of the Mantoux skin test with PPD-T (tuberculin), now available from the Michigan Department of Public Health has been established. Testing programs in the schools will be performed by physicians or by registered nurses under the direction of physicians.

Follow-up of reactors and their associates will be the responsibility of the local health departments and private physicians. Special reporting forms will be provided to the Michigan Department of Public Health to evaluate the program.

KELLOGG FOUNDATION FUNDS ENVIRONMENTAL STUDIES IN CITIES

The W. K. Kellogg Foundation of Battle Creek has granted \$442,380 to the National Sanitation Foundation of Ann Arbor to fund extensive surveys of environmental and ecological problems in certain Michigan cities.

The first survey is scheduled in Grand Rapids, where the plan is to organize projects necessary to reach and maintain a high quality environment. The Grand Rapids Center for Environmental Study, organized by businessmen and industrialists, individuals and educational, governmental and recreational organizations, will assist the Sanitation Foundation.

Pharmaceutical Association Has New Director

Louis M. Sesti, R.Ph., Lansing, is new executive director of the Michigan State Pharmaceutical As-



Mr. Sesti

sociation, succeeding Robert C. Johnson, R.Ph., who resigned as of Aug. 20, 1969. Mr. Johnson is now Executive Vice President of the California Pharmaceutical Association after nine years as Michigan director.

Mr. Sesti has served as MSPA director of professional services since 1966 and also as administrator of the Michigan Pharma-

ceutical Service Corporation since its formation in 1968. He has served also as associate editor of the *Michigan Pharmacist* and is a graduate of Ferris State College.

DOCTOR AGATE RETIRES; STATE EPIDEMIOLOGIST 15 YEARS

George H. Agate, M.D., Lansing, has retired after 15 years as state epidemiologist with the Michigan Department of Public Health. Doctor Agate, a pediatrician who has devoted much of his work to children and the retarded, plans to return to those fields.

In addition to work in epidemiology, Doctor Agate also initiated the state's rheumatic fever control program. In his 15 years of state service, he has seen the demise of polio, the dramatic reduction in measles and the potential elimination of Rubella.

He rates one of the most urgent problems today as that of transfusion hepatitis and notes that the "last full-blown case" of diphtheria in the state occurred three years ago, while only about six cases of typhoid occur in Michigan each year.

TEN COLLEGES AND UNIVERSITIES PROVIDING THE LARGEST NUMBER OF ENTERING FIRST-YEAR MEDICAL STUDENTS 1960-66

1960		1962		1964		1966	
School	No. of Entering Students	School	No. of Entering Students	School	No. of Entering Students	School	No. of Entering Students
*Harvard	164	MICHIGAN	169	Harvard	171	Harvard	176
*MICHIGAN	145	Harvard	146	Columbia	156	MICHIGAN	169
*Illinois	135	Illinois	115	MICHIGAN	153	Yale	143
*Columbia	130	Columbia	109	Cornell	123	Cornell	118
*Princeton	120	Indiana	109	Stanford	117	Calif., Berk	. 116
*Cornell	96	Yale	105	Penn. U.	112	Illinois	111
*Yale	95	Cornell	95	Calif., Berk.	110	Dartmouth	107
*Wisconsin	91	Minnesota	95	Indiana	106	Columbia	106
*Dartmouth	90	Princeton	95	Wisconsin	106	Indiana	105
*Indiana	90	Texas	95	Illinois	99	Stanford	101

From Datagrams
Association of American Medical Colleges



MAILBAG

Michigan Medicine invites letters of 300 words or less for publication. Communications should be addressed to the Publication Committee, Michigan State Medical Society, 120 West Saginaw, East Lansing, Michigan 48823. Unsigned letters will not be considered; but signed letters will be printed anonymously if the author so requests.

UPJOHN CO. REPLIES TO DOCTOR KELSO'S CRITICISM OF JAMA ADVERTISING

To the Editor:

I am writing you concerning Dr. Thomas Kelso's letter relative to J.A.M.A. advertising of the clinical laboratory services of The Upjohn Company which you published in your July issue.

The second paragraph of Dr. Kelso's letter clearly implies that a layman is directing the various clinical laboratories in our system. In fact, two of the three clinical laboratories in our system currently are directed by Pathologists, the third is directed by a Ph.D. Biochemist whose Medical Director is a Pathologist. Moreover, each of these laboratories is staffed with highly qualified professionals in each of the functions of their total. There are currently four Board-qualified anatomic and clinical pathologists within our system and seven Ph.D's.

Considering the need for high quality and large capacity laboratory services throughout the United States and the anticipated increase in this current need and considering further the high quality image and the reputation for scientific integrity held by The Upjohn Company, I think that it is regrettable that *Michigan Medicine* failed to publish with fair balance.

Sincerely,
Herbert H. McDade, Jr.
Divisional Director
Laboratory Procedures
The Upjohn Co.

THANK YOU FROM UNITED FUND

To the Editor:

The Michigan United Fund was very pleased to see how well you adapted the photographs taken at our recent budget conference for publication in *Michigan Medicine*. Judith Marr

was helpful in making some copies available for our personal use.

We like the introduction and the way the captions accompanying the pictures were handled, and greatly appreciate having had the opportunity for inclusion in *Michigan Medicine*.

Thank you very much for your interest and help.

Sincerely,
Olive Droste
Administrative Assistant
The United Fund
Lansing, Mich.

Study Reveals Rural Hospital Facts

Rural areas have better hospital facilities than most people think, according to a U.S. Department of Agriculture economist at Michigan State University.

Speaking before the annual meeting of the American Agricultural Economists Association, Leon B. Perkinson said that some rural counties can be expected to have more, rather than fewer, general hospital beds per 1,000 population, than their urban counterparts.

Perkinson said he recently completed a study of general hospital facilities in Michigan which showed that the availability of hospital beds per 1,000 population: (1) increases as the geographic location changes from the more urban to the more rural, (2) increases the farther a county is from a city of 25,000 population, and (3) increases when a town as large as 5,000 population is located within a county.

JACKSON PHYSICIAN FIRM AWARDS NURSING SCHOLARSHIPS

Noble-Blackmer, Inc., Jackson-based physician, hospital and surgical supply firm, has awarded four nursing scholarships to Christine Trudell, Jackson; Patricia Rozel, Whitehall; Kathi Shearer, Sturgis, and Gloria Jean Hurd, Jackson.

The scholarships are based on scholastic achievement and aptitude and may be used at any accredited school of nursing in the United States.

REPRINT REQUEST GRANTED PARKE-DAVIS

Permission has been granted the Rio de Janeiro branch of the Parke-Davis Co. to reprint in Portuguese an article which appeared in the November, 1967, issue of *Michigan Medicine*.

Entitled "A New Antipyretic Agent," the article was written by Charles F. Weiss, M.D., F.A.A.P., and Scott T. Harris, M.D., F.A.A.P., both of Ann Arbor.

YES, WE WELCOME MALPRACTICE INSURANCE INQUIRIES.

Call Us Collect From Anywhere In Michigan

Area I Wayne,	Limits	Class I	Class II	Class III	Class IV	Class V
Oakland And Genesee Counties	\$100/300,000	\$145.00	\$210.00	\$629.00	\$987.00	\$1,474.00
Area 2 Remainder of State of Michigan	\$100/300,000	\$145.00	\$210.00	\$453.00	\$686.00	\$907.00

Minimum Premium for Premises — \$33.00 (Premises Coverage Required)

Class I — Physicians — No surgery.

Class II — Physicians — Minor surgery or assisting in major surgery on own patients.

Class III — Surgeons — General practitioners who perform major surgery or assist in major surgery on other than own patients.

Class IV — Surgeons — Specialists.

Class V — Surgeons — Specialists — Anesthesiologists, Neurosurgeons, Obstetricians-Gynecologists, Orthopedists, Otolaryngologists.

Interns and Residents Coverage	Area 1 And 2
Interns	\$78.00
Residents (Class 1 & 2)	88.00
Residents (Class 3, 4, & 5)	215.00

BEN P. STRATTON AGENCY, INC.

P. O. Box 547, Lansing, Michigan 48903 Telephone: (517) 484-2578



(Editor's Note: The following article is quoted from the AMA Citation Newsletter of Aug. 1,

1969, prepared by the AMA Law Department).

SEXUAL DELINQUENCY AND SEXUAL PSYCHOPATHY

The sentencing of a sexually delinquent person to a term of one day to life following his conviction for making an indecent exposure was not improper on the ground that such a sentence for a sexually delinquent person constituted cruel and unusual punishment, a Michigan appellate court ruled. However, since a psychiatrist's testimony indicated that the accused's sexual conduct was due to a mental disorder, the trial court should have, on its own motion, instituted criminal sexual psychopath proceedings.

The punishment for indecent exposure is imprisonment for not more than one year or a fine of not more than \$500. The accused contended that the added penalty imposed on a sexually delinquent person violated the prohibition against cruel and unusual punishment because it was punishment for a mental condition or status.

The statute defines a "sexual delinquent" as a person whose sexual behavior is characterized by repetitive or compulsive acts indicating a disregard of consequences or rights of others, by the use of force, or by sexual aggressions against children. In contrast to this definition, a criminal sexual psychopathic person is defined as one who has a mental disorder which is coupled with criminal propensities to the commission of sex offenses. Sexual delinquents may be imprisoned for indeterminate

terms without provision for treatment, while sexual psychopaths are confined only for purposes of treatment and may not, following their release, be prosecuted for the offenses of which they were originally charged. In view of these differences it must be concluded that the meaning of "sexually delinquent person" excludes persons suffering from a mental disorder which is coupled with a propensity for the commission of sexual offenses. By necessary implication, a sexually delinquent person is one whose sexual conduct is not coupled with or due to any mental disorder. Thus, the added penalty of an indeterminate sentence imposed on a sexual delinquent did not constitute punishment for a mental condition.

The psychiatrist who examined the accused testified that he and most of his colleagues considered a condition such as the accused's as a personality defect rather than an illness. However, he further stated that the accused's conduct was not voluntary and that he might repeat the same type of act if he was eventually given his freedom.

In view of that testimony, the trial court should have initiated criminal sexual psychopath proceedings on its own motion. The reviewing court said that it was essential to the state's jurisprudence that it not punish mental disorder. — *People of the State of Michigan v. Griffes*, 164 N.W. 2d 426 (Mich., Feb. 7, 1969)

Vol. 19, No. 8

(Editor's Note: The following articles are quoted from the AMA Citation Newsletter of Aug. 15, 1969, prepared by the AMA Law Department.)

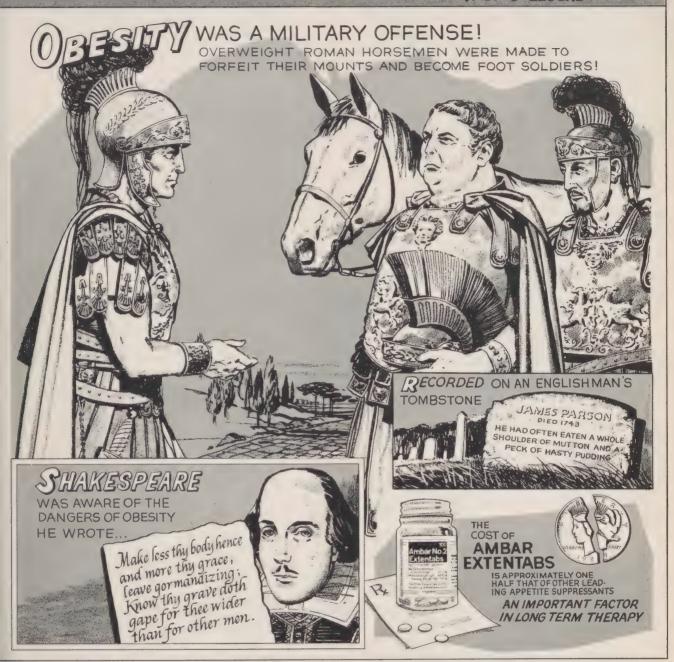
PSYCHIATRIC EXAM REQUIRED FOR ACCUSED

In a prosecution for assault with intent to murder and assault with intent to rape, a trial court should have granted the accused's request for a psychiatric examination to determine if he was a sexually psychopathic person, a Michigan appellate court ruled. It could reasonably be concluded from the facts alleged that the accused was a sexually psychopathic person. The sentences imposed on the criminal charges were set aside and the case remanded for a psychiatric examination of the accused and, if appropriate, a hearing on the question of whether he was a sexually psychopathic person.

An examination to determine whether an accused is a sexually psychopathic person is not to be ordered unless the petition alleges facts which tend to show or from which a conclusion of criminal sexual psychopathy could reasonably be drawn. A statement containing mere opinions, or one containing only allegations that the accused

Concluded on Page 1084

The AMBAR® ODESITY OCCUPIES



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Pheno-

barbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

AMBAR #2 EXTENTABS

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming). BRIEF SUMMARY/Indications: Ambar suppresses appetite and helps offset emotional reactions to dieting. Contraindications: Hypersensitivity to barbiturates or sympathomimetics; patients with advanced

renal or hepatic disease. Precautions: Administer with caution in the presence of cardiovascular disease or hypertension.

Side Effects: Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, A-H-ROBINS RICHMOND, VA. 23220

had been or was then charged with sexual offenses, is not sufficient. An allegation of prior convictions of sexual offenses is sufficient.

The accused alleged that he had on three occasions been convicted of contributing to the delinquency of a minor, that he had been charged with assault upon a minor with intent to rape, and that he had committed certain sexual indecencies.

The facts presented by the accused, apart from the pending charges, were not numerous. However, if true, they tend to show abnormal sexual tendencies at the least and a criminal sexual psychopath at the worst. In the interest of the individual and society, the examination should have been ordered, particularly since the request for an examination was not opposed by the prosecution. So far as the granting of the examination was concerned, it was immaterial that the accused, in requesting the examination, might have been motivated by the desire to be hospitalized rather than imprisoned. The accused's motivation could, however, be considered at the hearing stage. -People of the State of Michigan v. Shields, 162 N.W. 2d 679 (Mich., June 27, 1968; rehearing denied, Sept. 3, 1968)

NONCONSENTING MENTAL PATIENTS

A recent bar journal article considered the existing Michigan law as to the admission to mental hospitals of those persons in need of psychiatric care who will not voluntarily commit themselves. Certain changes in the law were recommended.

The commitment hearings now required in such cases do not serve their purported purpose of providing an independent judicial determination of the need for hospitalization, because the judge seldom, if ever, decides the case against the advice of the physician who, in testifying, recommends hospitalization. Further, such hearings delay hospitalization that may be urgently needed, and a court order of commitment adds to the stigma that attaches to hospitalization for mental illness.

The article recommends that, with respect to those persons who will not voluntarily commit themselves, but who do not actually protest commitment, a statute be enacted which permits them to sign a statement acquiescing in commitment and providing for immediate release upon request.

The article takes the position that the various provisions of the law relating to involuntary commitment, patterned after the rules of criminal procedure and adopted when there was fear that a person could be "railroaded" into a mental hospital, should be abandoned. The article recommends that something similar to the New York statute be adopted. Under that statute, a person is committed immediately upon the certification

of two physicians of the need for hospitalization. The patient is entitled to a hearing within five days, and at specified intervals thereafter, as to the need for hospitalization, and, in such hearings, he is entitled to due process.—Nonconsenting Mental Patients, Gerald S. Clay and Ross W. Campbell, 48 Michigan State Bar Journal 23 (April, 1969)

TESTIMONY BY PSYCHIATRISTS EXAMINING ACCUSED WITHOUT ATTORNEY

In a murder prosecution in which the defense of insanity was raised, the accused's right to counsel and privilege against self-incrimination were not violated by the admission of the testimony of two psychiatrists who examined him before counsel was appointed for him, a Michigan appellate court ruled.

The accused surrendered himself to the police at midnight and told them that he was the killer whom they were looking for. He was offered assistance of counsel, which he declined. While the police were taking his formal confession, the prosecutor made arrangements to have the two psychiatrists examine him at 8:00 a.m. When he was told about the examination, the accused said that he thought that he had better have an attorney. He was told that he would have to wait for appointment of counsel until a judge was available later in the morning.

The accused talked freely with the psychiatrists during their two-hour examination.

Counsel was appointed for the accused later that same day.

At the trial, the psychiatrists were permitted to testify that on the basis of their examination they were of the opinion that the accused was sane. The accused contended that the admission of the testimony violated his right to counsel and his privilege against self-incrimination.

The accused intelligently and voluntarily waived his right to counsel before he made his confession. Since this case was tried in 1964, it was not necessary to consider the effect, with respect to his request for an attorney before the examination, of the rule adopted in 1966 that the interrogating must cease at any one of the "critical stages" of the proceedings upon the demand of the accused for an attorney.

There was no violation of the accused's privilege against self-incrimination. Although he knew he had the right to remain silent, he voluntarily talked with the psychiatrists. There was no evidence whatsoever of any adverse testimonial compulsion. — People of the State of Michigan v. Ranes, 163 N.W. 2d 807 (Mich., Sept. 4, 1968)

Vol. 19, No. 9



unwelcome bedfellow for any patient-including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information - Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. Indications: For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. Contraindications: QUINAMM is contraindicated in pregnancy because of its quinine content. Precautions/Adverse Reactions: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. Dosage: One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. Supplied: Bottles of 100 and 500 tablets.



THE NATIONAL DRUG COMPANY DIVISION OF RICHARDSON-MERRELL INC PHILADELPHIA, PENNSYLVANIA 19144

Specific therapy for night leg cramps



Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem recent studies report increased incidence, attributed in part to the use of oral contraceptives, 1-4 broad-spectrum antibiotics 5-9 and prolonged use of corticosteroids. 7 recent evidence establishes high rate of microbiological and clinical cure with AVC.9-11

Comprehensive - Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfon-

Precautions/Adverse Reactions: The usual precau-Precautions/Adverse Reactions: The usual precau-tions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue

treatment.

Dosage: One applicatorful or one suppository in-

travaginally once or twice daily.

Supplied: Cream — Four-ounce tube with or without applicator. Suppositories — Box of 12 with applicator.

Applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec.

93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.



THE NATIONAL DRUG COMPANY PHILADELPHIA, PENNSYLVANIA 19144

CREAM (aminacrine hydrochloride 0.2%, sulfanilamide 15.0%, allantoin 2.0%)

SUPPOSITORIES (aminacrine hydrochloride 0.014 Gm., sulfanilamide 1.05 Gm., allantoin 0.014 Gm.)



symptoms of mixed anxiety-depression are rarely clear-cut...
but they are often a clear indication for

Mellarii[®] (thioridazine) 25 mg. t.i.d.

effective in mixed anxiety-depression and in moderate to severe anxiety

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: Central Nervous System—
Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. Autonomic Nervous System—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. Endocrine System—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. Skin—Dermatitis and skin eruptions of the urticarial type, photosensitivity. Cardiovascular System—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. Other—A single case described as parotid swelling.

SANDOZ PHARMACEUTICALS, HANOVER, N.J. SANDOZ 69-384

Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic / antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also,

at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible

combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

PRECAUTIONS: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and toler-



nted). Though generally not recommended, if ombination therapy with other psychotropics eems indicated, carefully consider individual harmacologic effects, particularly in use of poentiating drugs such as MAO inhibitors and henothiazines. Observe usual precautions in resence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psyliatric patients. Employ usual precautions in reatment of anxiety states with evidence of impending depression; suicidal tendencies may be resent and protective measures necessary. Variable effects on blood coagulation have been eported very rarely in patients receiving the lung and oral anticoagulants; causal relationing has not been established clinically.

rip has not been established clinically.

ADVERSE REACTIONS: No side effects or nanifestations not seen with either compound the have been reported with Librax. When shlordiazepoxide hydrochloride is used alone, trowsiness, ataxia and confusion may occur, specially in the elderly and debilitated. These

are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.



Division of Hoffmann-La Roche Inc. Nutley, New Jersey 07110



MSMS Meets the John Birchers

BY BROOKER L. MASTERS, M.D., FREMONT CHAIRMAN, MSMS PUBLICATION COMMITTEE

Our Michigan State Medical Society and its journal, *Michigan Medicine*, have recently been "discovered" by the John Birch Society. No longer are we to see only the "Impeach Earl Warren" highway signs. Recently each one of us received a copy of the *John Birch Society Bulletin* for September 1969 which dealt with MSMS to a large degree.

We trust many of you saw this *Bulletin* and read it, for it clearly pinpoints the dangerous state which extremism is reaching in the U.S.A.

The cause for this special attention from Robert Welch was the publication in the May issue of Michigan Medicine of the three articles written by Michigan doctors and describing the merits of family education courses in the public schools. Many courses have been planned and instigated chiefly by Michigan physicians with the view of reducing the high incidence of illegitimacy, unhappiness, promiscuity, and divorce which result from ignorance on the important subject of intimate association between the sexes.

It was in response to these articles that the September issue of the Birch Society Bulletin was written and they are the reason why every member of MSMS was mailed a copy by the Birch Society.

AT FIRST GLANCE, this attention by the John Birchers might be considered a compliment, or at least encouraging. We always like to know that *Michigan Medicine* is being read, and it is our policy to present all aspects of any issue.

However, the charges leveled at MSMS members by this Birch Bulletin are so preposterous as to make us all scratch our heads in wonderment: "Why us?" So we have been doing some research into why, and the facts uncovered are hairy, to say the least.

It is my opinion after surveying reams of publicity published in all the news media throughout the country that the recent outpouring of opposition to sex education in our schools is in part the result of the efforts by the John Birch Society to use this tool to discredit our school system—its boards, administrators, and teachers—not just in Michigan but in all the 50 states. And not just to thwart the development of badly-needed programs in family living, but to raise doubts in the minds of more and more of the average citizens and to question our entire system. This is a clear example of the maneuverings of an extremist group, and they are showing their colors to us physicians.

Now there may be a Communist in our medical

BIRCH SOCIETY ATTACKS ARTICLES IN MAY ISSUE BY MICHIGAN DOCTORS

The John Birch Society has objected to three articles which appeared in the May issue of *Michigan Medicine* authored by R. T. Mellis, M.D., Kalamazoo, chairman of the MSMS Lay Education Subcommittee of the Committee on Maternal Health; by Frederick J. Margolis, M.D., Kalamazoo, producer of several nationally-recognized family life education films, and by E. C. Galsterer, M.D., Saginaw, member of the Maternal Health Committee.

Doctor Mellis, in his article on pages 518 and 519, described the tactics of the John Birch Society and urged MSMS members "to actively resist their attacks and to support good sex education in the public schools."

Doctor Margolis, in his article on 519-520-521, offered a positive five-step program for quality sex education programs. Doctor Margolis, in part, wrote: "The Birch group is not limiting its attack to the field of sex education. Similar irresponsible harassment is being made on the schools and local governments in an effort to divide the community and frighten citizens into their camp."

Doctor Galsterer, in his article on pages 521-522, stressed that "sex education is only one small part of an overall program" of family life education. He was critical of the John Birch Society because it "fails to recognize the value of this health education program as a whole."



EDITORIAL VIEWS

society ranks but he is a lonely soul. (I have never met one.) All the many doctors who have worked for and promoted sex education in our schools know that the Birch charges are a pack of misrepresentations and gross untruths.

* * *

SEX EDUCATION IN OUR schools has been conceived and taught as a well-rounded subject in family living to better prepare our youngsters to cope with today's complex social environment in which the home is assuming a lesser role in the training of our children.

Surveys show that 70-80% of children receive no training related to this subject in their homes. Those who have worked in the field of family education know that "raw sex" enters into it hardly at all, and then only as a totally related concept in the development of the entire life of the individual, just as sex should be; not as *the* focus of his life.

Charges such as those levelled by the John Birchers against MSMS and *Michigan Medicine* are the work of extremists. Their mark is that of irresponsibility and their method is to label everything of which they disapprove as being "Communist."

* * *

DOCTORS OF MICHIGAN, perhaps you know better now the tactics of the extreme right. They sound just as destructive as the extreme left. You are accused by them. We should awaken and actively speak out against extremism before it is too late.

Michigan Students To Have Superior Health Education

BY E. GIFFORD UPJOHN, MD, PRESIDENT MICHIGAN HEALTH COUNCIL

Thanks to extraordinary teamwork by the health and educational organizations that participate in the programs of the Michigan Health Council, Michigan students of the future will have an opportunity to gain information on critical health matters as provided in the new Critical Health Problems Education Act,

The program shall be to educate Michigan Youth with regard to critical health problems and shall include, but not be limited to, the following topics as the basis for comprehensive education curricula in all elementary and secondary schools: drugs, narcotics, alcohol, tobacco, mental health,

dental health, vision care, nutrition, disease prevention and control, accident prevention and related health and safety topics. An appropriation of \$75,000 was made to the State Department of Education to help implement the new legislation during the coming school year.

GREAT CONCERN

This legislation, HB 3261, came about because of the great concern The Council had for the lack of adequate health education in most schools, not only in Michigan but throughout the Nation. Because of this concern, John A. Doherty, MHC Executive Director, and Benjamin H. Yep, Coordinator of the Council's smoking and health program, worked with Representative Dale Warner of Eaton Rapids, Chairman of the House Special Subcommittee on Drug Abuse, Rep. William Fitzgerald, Chairman of the Public Health Committee, and Rep. Jack Faxon, Vice Chairman, House Appropriation's Committee.

The Michigan Health Council prepared a model Bill.

With 66 co-signers, House Bill No. 3261 passed the House; and, with strong support from Senators Stamm and Bursley and others, the Bill passed the Senate 32-0. Favorable action was taken and, in the Joint Appropriations Committee of the House and Senate, an agreement was made to appropriate \$75,000 to implement this important legislation.

UNUSUAL ACTION

The Michigan Health Council, as a voluntary organization, does not usually become involved in legislation. The need for this type of education for Michigan students was deemed to be so imperative that the Council, and particularly Mr. Yep and Mr. Doherty, did spend much time and effort on this legislation.

Many letters of appreciation have already been received from Michigan health educators who consider this new act one of the most important ever passed for the benefit of the health of Michigan students. The Council has received many inquiries from other state health organizations as well as from the National Clearinghouse on Smoking and Health, and the American Medical Association's Department of Health Education. There is every indication that the legislation that was signed by Governor William Milliken will be used as a model throughout the Nation.

The Michigan Health Council is deeply appreciative of the strong support given by so many members and organizations that make up the Michigan Health Council and the Michigan Council on Smoking and Health in helping to prepare the legislation as well as urging their representatives and senators and the Governor to support HB 3261, the Critical Health Problems Education Program for Michigan youth.



Ornade Spansule brand of sustained release capsules

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.

Prompt relief from nasal congestion and hypersecretion due to colds.

Before prescribing, see complete prescribing information in SK&F literature or PDR.

Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction

Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.

Usage In Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when

potential benefits have been weighed against possible hazards.

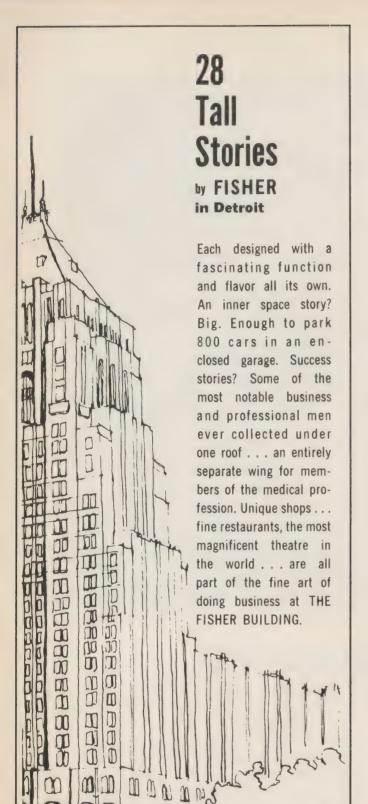
Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I131 uptake; discontinue 'Ornade' one week before these tests.

Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia.

Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported Supplied: Bottles of 50 capsules

One capsule q12h for round-the-clock relief

SK SF Smith Kline & French Laboratories



Call or write the Rental Office

THE FISHER BUILDING

Across from the General Motors Bidg.

Detroit, Mich. 48202 (313) 874-4444





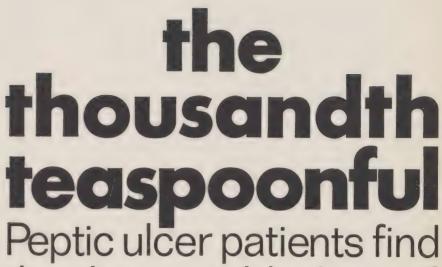
Consider these three important additions in the expansion and upgrading of your diagnostic and therapeutic patient services — the EK 4 Electrocardiograph, the MW-200 Microwave Diathermy, and the UT/4300 Ultrasound/Stimulator.

Each can play an important role in your practice. All are simple to operate. No need for additional or specially trained personnel. Most important is the availability of wider services for your patients, with fewer referrals. If you already have one of these units, consider the addition of new equipment in keeping with your practice needs.

Call for an equipment check-up.

BURDICK

THE G. A. INGRAM COMPANY 4444 Woodward Avenue, Detroit, Michigan 48201 Telephone: TEmple 2-4444



Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!

Optimal neutralization—provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste—confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.¹

Concomitant relief of G. I. gas distress—provided by the proven antiflatulent action of simethicone.²

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonfuls to be taken between meals and at bedtime, or as directed by physician.

References: 1. Danhof, I. E.: Report on file. 2. Hoon, J. R.: Arch. Surg. 93:467 (Sept.) 1966.

Mylanta LIQUID/TABLETS

aluminum and magnesium hydroxides plus simethicone



Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109



NEWS BRIEFS

W. G. GAMBLE, JR., M.D., BAY CITY,

recently was named a Fellow Emeritus in the International College of Surgeons, with full privileges.

ROGER B. NELSON, M.D., ANN ARBOR,

recently retired former senior associate director of University Hospital, Ann Arbor, has accepted a position effective Aug. 5 as executive director and consultant for Pontiac General Hospital. He served 19 years in his former post.

L. LEO TINKEY, M.D., WARREN,

a pediatrician, became clinic director at Gaylord State Home on Aug. 4, succeeding R. S. Libke, M.D., who resigned to become Gaylord's public health director.

ALFRED H. WHITTAKER, M.D., GROSSE POINTE.

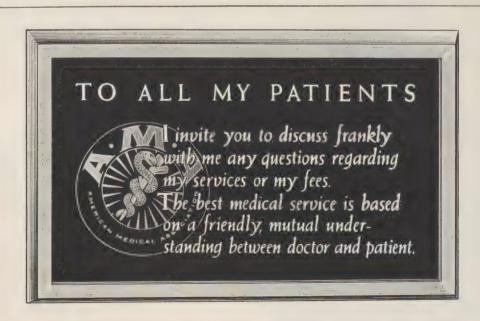
contributed a paper entitled "The Heiratic Writing of the Edwin Smith Surgical Papyrus," at the 29th annual convention of the American Medical Writers Association Sept. 19-20 in Philadelphia. Doctor Whittaker is president of the Michigan chapter of the AMWA and is a member of the Board of Governors of Wayne State University.

JOHN R. YLVISAKER, M.D., BLOOMFIELD HILLS,

has accepted the position of medical director of the St. Joseph Mercy Hospital staff, Pontiac.

A. L. ZILIAK, M.D., BAY CITY

and his family are hosts through the coming winter to a Japanese sister and brother, Mitsuyo and Kazuo Nushihara, who are in America learning English, attending one semester at Delta College, and in Kazuo's case, teaching judo. Mitsuyo is learning English in preparation for serving as a hostess at Japan's World's Fair next year.



This attractive office plaque, available from the American Medical Association, will encourage better understanding between you and your patients. Suitable for wall or desk display, the plaque measures 6" x 101/2". The lettering is white on a dark brown background and the frame is durable beige plastic. The plaque is designed to blend well with any office decor. Cost of the plaque is \$1.25, postpaid. To place your order, write to the Order Department, American Medical Association. Make check payable to the AMA.

AMERICAN MEDICAL ASSOCIATION 535 North Dearborn Street . Chicago, Ill. 60610



No injection after all! This penicillin produces high, fast levels-orally.

Pen·Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease. Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

mistory of penicillin sensitivity. Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia.

In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.

Precautions: In suspected staphylococcal infections, perform proper Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.

Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfolia-tive dermatitis; urticaria; serum sickness-like reactions, including

tive dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").

Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); itquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL PEN·VEE® K

(potassium phenoxymethyl penicillin) [Wyeth]





COUNTY SOCIETIES

BAY DOCTORS COMPETE AT GOLF

Members of the Bay, Arenac and Iosco Counties Medical Society competed in the annual Doctor-Dentist-Druggist Golf Tournament Sept. 24 at the Bay City Country Club. Richard Bickham, M.D., represented the doctors on the planning committee and an invitation was extended for the first time to local osteopaths. All were competing against last year's champion, Robert Antle, M.D., who had walked off with laurels the past two years.

OAKLAND SOCIETY JOINS NATIONAL CONGRESS

The Oakland County Medical Society Board of Directors voted recently to join the Congress of County Medical Societies, an organization founded in 1965 as a forum for discussion of matters of mutual interest to county medical societies. The move was made by the Oakland board.

WAYNE ELECTS FOUNDATION TRUSTEES

The Wayne County Medical Society Council has elected Louis Heideman, M.D., F. P. Rhoades, M.D., and Mr. George Parker to three-year terms as trustees of the Wayne County Health Foundation. The Foundation was established in 1965 to administer the monies resulting from the Polio Campaign.

WAYNE CONTRIBUTIONS HELP FURNISH READING ROOM

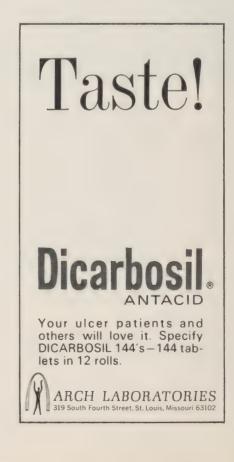
Contributions from Wayne County Medical Society members, through the Wayne State University Medical Alumni Library Fund, and gifts from the Wayne County Health Foundation will furnish a reading room in the WSU Medical School Library now under construction. The library is scheduled to be completed in 1970. The reading room will be named for William J. Stapleton, Jr., M.D., long-time Detroit physician, dean emeritus of WSU Medical School and the MSMS Historian.

KALAMAZOO DOCTORS, CLERGY GATHER

LeRoy Augenstein, Ph.D., chairman of the Michigan State University Biophysics Department and a member of the State Board of Education, was guest speaker at the Clergy-Doctor Dinner Meeting staged Sept. 10 by the Kalamazoo Academy of Medicine. Bronson Hospital was sponsor.

MANISTEE DOCTORS OFFER FREE SPORTS EXAMS

The Manistee County Medical Society, in cooperation with local osteopaths and dentists, is sponsoring free physical examinations to all Manistee Catholic Central High School boys going out for any sports during the school year. The exams for the Catholic school boys are given at the same time as those to the public school students.



in the treatment of

(thyroid-androgen) TABLETS

Effectiveness confirmed by another double blind study*

1 SHMMARY ANDROID

GOOD TO EXCELLENT 75%

PLACEBO

*"Sexual impotence treatment with methyl testosterone - thyroid (ANDROID) a double blind study" - Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS — Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the Thyroid is not to be used in heart disease, hypertension unless the

Choice of 4 strengths Android Android-HP

HIGH POTENCY

Each vellow tablet contains: Methyl Testosterone . . 2.5 mg. Thyroid Ext. (1/6 gr.) . . 10 mg. Methyl Testosterone . . 5.0 mg Thyroid Ext. (½ gr.) . . . 30 mg50 mg. Glutamic Acid Thiamine HCL Thiamine HCL Dose: 1 tablet 3 times daily. Dose: 1 tablet 3 times daily. Bottles of 100 500 1000 Bottles of 100, 500, 1000.

Write for literature and samples:

THE BROWN PHARMACEUTICAL CO. 2500 W. 6th St., Les Angeles, Calif. 90057

Android-X

EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone , 12.5 mg.
Thyroid Ext. (1 gr.) 64 mg.
Glutamic Acid 50 mg
Thiamine HCL 10 mg
Dose: 1 or 2 tablets daily.
Available:
Rottles of 60 500

PDR

2. Forty cases reported.

- Cites synergism between androgen and thyroid.
 No side effects in patients treated.

- 5. Alleviation of fatigue noted 6. Case histories on 4 patients. 7. Although psychotherapy still needed, role of

chemotherapy cannot be disputed.

Android-Plus WITH HIGH POTENCY B-COMPLEX AND VITAMIN C Each white tablet contains:

Methyl Testosterone ... 2.5 mg. Thyroid Ext. (1/4 gr.) ... 15 mg. Ascorbic Acid (Vit. C) ... 250 mg.

Vitamin B-122.5 mcg

Available: Bottles of 60, 500.

Dose: 2 tablet twice daily

Riboflavin

also available with ESTROGEN

Android-E

Each Tablet Contains:

Glutamic Acid 50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen —only steroid effect remains. Geriatrics, post-operative and debilitating disease, ost-opporosis. DOSE: One tablet Lid. Female patients should have a rest period 5 to 7 days after 21 days of medication. SIDE EFFECTs: In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsulism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. CONTRA-INDICATIONS: See Android. Ethinyl estradiol is not to be Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

Established 1924

MERCYWOOD HOSPITAL

4038 Jackson Road

Conducted by Sisters of Mercy

Ann Arbor, Michigan

Telephone — 313 663-8571



Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

Accredited by the Joint Commission on Accreditation of Hospitals and the National League of Nursing. A full Blue Cross participating hospital.

Certified for: Medicare and M.A.A. programs

PSYCHIATRIC STAFF

Lyle M. Allis, M.D. Robert J. Bahra, M.D. Dean P. Carron, M.D. Francis M. Daignault, M.D. Sydney Joseph, M.D.

James R. Driver, M.D. Stuart M. Gould, Jr., M.D. Richard D. Watkins, M.D. Leonard E. Himler, M.D.* Gordon C. Dieterich, M.D. Jacob J. Miller, M.D.

Rudolf Nobel, M.D. Stephen C. Mason, M.D. Philip M. Margolis, M.D. Hubert Miller, M.D.

* 1904 - 1967

Indication: Mental depression.

Contraindications: Do not use MAO inhibitors concomitantly or within 2 weeks of the use of this drug. Hyperpyretic crises or severe convulsive seizures may occur with such combinations; potentiation of adverse reactions can be seri-

combinations; potentiation of adverse reactions can be serious or even fatal.

When substituting Pertofrane in patients receiving an MAO inhibitor, allow an interval of at least 14 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.

The drug is contraindicated following recent myocardial infarction and in patients with a known hypersensitivity to triguelia antidepresents.

Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Due to atropine-like effects and sympathomimetic potentiation, use only with the greatest care in patients with narrow-angle glaucoma or urethral or ureteral spasm.

Do not use in patients with the following conditions unless the need outweighs the risk: severe coronary heart disease with EKG abnormalities, progressive heart failure, angina pectoris, paroxysmal tachycardia and active seizure disorder (may lower seizure threshold).

Desipramine and the parent compound, imipramine, have been shown to block the action of guanethidine and related

been shown to block the action of guanethidine and related adrenergic neuron-blocking agents.

Hypertensive episodes have been observed during surgery. The concurrent use of other central nervous system drugs or alcohol may potentiate adverse effects. Since many such drugs may be used during surgery, designames should be discontinued prior to elective procedures.

Caution patients on the possibility of impaired ability to operate a motor vehicle or dangerous machinery.

Do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk, and do not use in patients under 12 years of age.

Because of increased sensitivity to the drug, use lower than normal dosage in adolescent and geriatric patients.

Precautions: Potentially suicidal patients require careful supervision and protective measures during therapy. Discontinuation of the drug may be necessary in the presence of increased agitation and anxiety shifting to hypomanic or

of increased agitation and anxiety shifting to hypomanic or manic excitement

Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anti-cholinergic drugs (including antiparkinsonism agents). Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications, transient cardiac arrhythmias

have occurred in rare instances.

Periodic blood and liver studies should supplement careful

clinical observations in all patients undergoing extended courses of therapy

Adverse Reactions: The following have been reported: Nervous System: dizziness, drowsiness, insomnia, headache, disturbed visual accommodation, tremor, unsteadiness, tinnitus, paresthesias, changes in EEG patterns, epileptiformseizures, mild extrapyramidal activity, falling and neuro-muscular incoordination. A confusional state (with such symptoms as hallucinations and disorientation), particularly in older patients and at higher dosage, may require disconsinuation of the drug. Gastrointestinal Tract: anorexia, dryness of the mouth, nausea, epigastric distress, constipation and diarrhea. Skin: skin rashes (including photosensitization), perspiration and flushing sensations. Liver: rare cases of transient jaundice (apparently of an obstructive nature) and liver damage. If jaundice or abnormalities in liver function tests occur, discontinue the drug and investigate. Blood Elements: bone-marrow depression, agranulocytosis, thrombocytopenia and purpura. If these occur, discontinue the drug. Transient eosinophilia has been ob-Adverse Reactions: The following have been reported: locytosis, thrombocytopenia and purpura. If these occur, discontinue the drug. Transient eosinophilia has been observed. Cardiovascular System: orthostatic hypotension and tachycardia. Carefully supervise patients requiring concomitant vasodilating therapy, particularly during initial phases. Genitourinary System: urinary frequency or retention and impotence. Endocrine System: occasional hormonal effects, including gynecomastia, galactorrhea and breast enlargement, and decreased libido and estrogenic effect. Sensitivity: urticaria and rare instances of drug fever and cross-sensitivity with miproramine.

effect. Sensitivity: United a and rare instances of orag leval and cross-sensitivity with impramine.

Dosage: All patients except geriatric and adolescent.
50 mg. t.i.d. (150 mg. daily). Dosage may be increased usually be started with lower dosage (25 to 50 mg. daily) and may not tolerate higher doses. Dosage may be increased usually be started.

up to 100 mg. daily

Lower maintenance dosages should be continued for at least 2 months after obtaining a satisfactory response.

Mild anxiety and agitation which may accompany depression usually remit as the depression responds. Occasionally,

however, a sedative or tranquilizer may be indicated.

Availability: Marcon and pink capsules of 50 mg. in bottles of 100; pink capsules of 25 mg. in bottles of 100 and 1000. (B)46-530-G

For complete details, please see the full prescribing infor-

reigy

Coming out of a depression.

And it can often begin to happen in 3 to 5 days with an antidepressant like Pertofrane. There's a lifting of depressed mood...a restoration of psychomotor activity. Patients usually begin to cope, work, maybe play, even enjoy.

It's not all beautiful. Sometimes there are side effects. And not everybody can take the drug. It may even be a slow process. But along with the care and comfort you give depressed patients, consider Pertofrane. Then consider the response.

Please read the prescribing information for full details on contraindications, warnings, precautions, adverse reactions and dosage. It's summarized on the left.

Pertofrane

desipramine hydrochloride New 50-mg. capsules now available.

It's beautiful!



IN MEMORIAM

MICHIGAN MEDICINE would greatly appreciate notification from Michigan doctors of the deaths of local physicians who are MSMS members.

At present newspaper clippings are the major source of information and long delays sometimes result between the time of death and publication of memorials in the journal.

Henry Archambault, M.D. Jirape, Ghana

Henry Archambault, M.D., former Detroit physician, died July 17 in a hospital he had helped build in Jirape, Ghana. He was 57.

The medical missionary had formerly been in private practice in Detroit for 20 years and on the staff of Providence Hospital. He went to Ghana in 1960 to fulfill a promise that if he recovered from tuberculosis he would devote his life to missionary work.

Doctor Archambault was a graduate of the University of Pennsylvania College of Medicine.

Harry F. Becker, M.D. Battle Creek

Harry Francis Becker, M.D., Battle Creek, former medical director of Michigan Blue Cross, died July 25 at the age of 78.

Doctor Becker, a Battle Creek pediatrician for 26 years, was graduated from the University of Michigan School of Medicine. As medical director of Michigan Blue Cross following World War II, he conducted, in cooperation with MSMS, the nation's first comprehensive and large scale study of increasing hospital utilization and its effect on hospital insurance costs.

He was former president of the Calhoun County Medical Society and had served as chief of staff at Leila Hospital and chief of pediatrics at Leila and Community Hospitals, Battle Creek. He was a former president of the Western Michigan Pediatric Association, a diplomate of the American Board of Pediatrics, and a member of the American Academy of Pediatrics and the Detroit Pediatric Association.

Earl W. Brubaker, M.D. Lansing

Earl Witten Brubaker, M.D., long-time Lansing pediatrician, died Aug. 7 at the age of 72.

Doctor Brubaker was a graduate of Wayne State University School of Medicine and belonged to the American Academy of Pediatrics. He was affiliated with St. Lawrence and Edward W. Sparrow Hospitals in Lansing.

John H. Curtin, M.D. Flint

John H. Curtin, M.D., Flint, former president of the Genesee County Medical Society, died Aug. 8 at the age of 73.

Doctor Curtin retired in 1960 as medical director of AC Spark Plug Division and had previously been named Flint's health officer. In 1951 he was awarded a fellowship in the American Association of Industrial Physicians and Surgeons for "important contributions in the field of industrial health."

He was a graduate of the University of Michigan School of Medicine.

Harry H. Johnson, M.D. Wayland

Harry Hinds Johnson, M.D., Wayland physician for over 20 years, died July 26 at the age of 89.

Doctor Johnson was graduated from the University of Kansas Medical School and was affiliated with Crispe Hospital, Plainwell. He was a general practitioner.

R. Gerald Jordan, M.D. Grosse Pointe Shores

R. Gerald Jordan, M.D., long-time Detroit physician, died Aug. 23 at the age of 60 at his home in Grosse Pointe Shores.

Doctor Jordan, a graduate of Wayne State University School of Medicine, was a member of the staff of Doctors Hospital, Detroit, and belonged to the American Academy of General Practice.

Walter Harmon, Jr., M.D. Detroit

Walter Harmon, Jr., M.D., Detroit general practitioner, died July 4 at the age of 60.

Doctor Harmon was a graduate of Howard University School of Medicine and was a general practitioner. He was affiliated with St. Francis Hospital, Hamtramck.

Douglas B. McDowell, M.D. Tucson, Ariz.

Douglas B. McDowell, M.D., West Branch practitioner for 20 years before retiring to Tucson, Ariz., died Aug. 6 at the age of 61.

Doctor McDowell was a graduate of New York University School of Medicine and was former director of the General Hospital Division of Wayne County General Hospital in Eloise.

He was a specialist in hospital administration and was a former president of the North Central Michigan Medical Society.

Vassal G. Tolbert, M.D. Detroit

Vassal G. Tolbert, M.D., Detroit physician for 31 years, died July 26 at the age of 69.

Doctor Tolbert was on the staff of Kirkwood General Hospital and was formerly medical director at the Edith K. Thomas Hospital in Detroit. He was graduated from Meharry Medical College where he had been on the teaching staff, and was a member of the National and Detroit Medical Associations. He was a life member of the NAACP.

G. Douglas Treadgold, M.D. Port Huron

G. Douglas Treadgold, M.D., Port Huron physician for 42 years, died July 30 at the age of 76.

Doctor Treadgold was a graduate of the University of Michigan Medical School and was a former director of anesthesia at Port Huron Hospital. He retired fully in 1968.

By Patronizing

Our Advertisers

You Help Support

MICHIGAN MEDICINE

INGRAM'S SERVICE DEPARTMENT

ALL FACTORY TRAINED MEN

We service Medical Equipment, Electrocardiographs, Basal Metabalors, Sterilizers, Autoclaves, Diathermy Outfits, Cutting Units, Ultra Violet Lamps, Hydro Therapy Units, Laboratory Equipment. ALL BURDICK, LIEBEL FLARSHEIM AND RITTER EQUIPMENT.

If you have any Service problems, please call us at TE 2-4444, ask for the SERVICE DEPARTMENT and we will gladly help in any way we can.

THE G. A. INGRAM COMPANY

4444 Woodward Avenue

TEmple 2-4444

Detroit, Michigan 48201

Classified Advertising

\$5.00 per insertion of 50 words or less, with an additional 10 cents per word in excess of 50.

- MEDICAL SUITE Newly decorated with two examination rooms, reception room and consultation office in air conditioned building. Adjacent to Beaumont Hospital at 3023 N. Woodward Avenue, Royal Oak. Will consider concession at the start. There are 5 successful M.D.'s, dentist, Pharmacy and Laboratory located in our building. By appointment, contact William F. Fordon, Phone (313) 477-8181.
- WANTED: City Physician for employment exam center and public health consultation. Attractive to physician who wants activity limited to a standard work week. Contact D. L. Sherman, Personnel Director, City Hall, Dearborn, Michigan 48126. (313) LU 4-1200.
- PSYCHIATRIC RESIDENCIES: We offer nothing but excellent psychiatric training in a stimulating, well organized program located in a culturally advantaged community. Approved psychiatric training. Traverse City State Hospital, Michigan Department of Mental Health. Three and five year programs. Salary, 3 year program: \$10,669; \$11,191; \$12,131. Five year program: \$12,152; \$14,031; \$16,328; \$21,994; \$23,093. MIMH-GP stipends available. Located in Michigan's serene, scenic recreation area on Grand Traverse Bay. Contact Dr. Paul E. Kauffman, Director of Training, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.
- PRACTICE OPPORTUNITY—Active General practice in progressing community 30 miles north of Detroit. Modern office, fully equipped and staffed. Present gross over \$70,000 in four day week. Will introduce M.D. or D.O. Priced for immediate sale or lease. Reply Box #10, 120 W. Saginaw Street, East Lansing, Michigan.
- WANTED: General Practitioner for private and industrial practice Suburban Detroit, full or part-time. Terms open. Michigan license required. Reply Box 162, Madison Heights, Michigan 48071.
- FOR SALE: A 100 foot nicely wooded lot on Lake Michigan, four miles south of Manistee. A beautiful setting for a cottage or retirement home located in The Professional Club, a private organization. For inquiry write or call V. E. Cortopassi, M.D., 221 Ardussi Street, Saginaw, Michigan 48602. Telephone (517) 793-1565.
- FOR SALE: Plastic surgeon's complete office equipment and surgical instruments. Write Estate of John H. Packer, M.D., 2909 E. Grand River, Suite 111, Lansing, Michigan 48912.
- WANTED: Younger general surgeon-GP for opening in busy established practice in town of 3500 in N.E. Minn. Salary \$45,000 first year, then partnership. T. C. Leach, M.D., Babbitt Clinic, Babbitt, Minnesota 55706.

- GENERAL PRACTITIONER needed for established multi-specialty group in Detroit. Excellent professional relationship. Reply to Box: #9, 120 West Saginaw Street, East Lansing, MI 48823.
- RADIOLOGIST, full-time, for accredited hospital in Detroit. Excellent remuneration. Reply to Box: #10, 120 West Saginaw Street, East Lansing, Michigan 48823.
- DOCTORS! Monroe, Michigan, City of 30,000 County of 100,000. Located Lake Erie near Toledo, Detroit. Excellent schools, community college, 300 beds in two new hospitals. Openings for General, ENT, Urology, Orthopedic Surgery. Contact: R. W. Wilkins, M.D., Secretary Monroe County Medical Society, 118 Cole Road, Monroe, Michigan 48161
- INTERNIST: Board certified or eligible. 233 bed hospital in Michigan's vacationland. All seasons sports resort area, skiing, hunting, fishing. Licensure any state. Salary based on qualifications. Excellent fringe benefits. Non-discrimination in employment. Contact, Chief of Staff, VA Hospital, Iron Mountain, Michigan 49801.
- IMMEDIATE VACANCIES FOR SPECIALISTS OR G.P.'S in medical department of a large institution for the mentally retarded. Institution includes a large patient residential area, a pediatric building accommodating some 200 children, a 100 bed infirmary, a 200 bed general hospital with medical, surgical and selective surgery wards, an active O.R., well equipped diagnostic facilities; clinical and genetic research laboratories, X-ray Dept., P.T. Dept., etc. Annual Salary ranges from \$20,000 to \$27,000 depending on qualifications. Michigan licensure, or ECMFG for foreign graduates is required. Contact: Isak O. Berker, M.D., Medical Director, Lapeer State Home and Training School, Lapeer, Michigan 48446.



"I do this at every party as soon as it gets out I'm a doctor."

Index to Advertisers They Help Make Michigan Medicine Possible

Arch Laboratories1094	National Drug CompanyCover II, 1081, 1082
Bristol Laboratories	Parke, Davis & Company1086
Brown Pharmaceutical Co	Pfizer Laboratories
Burroughs Wellcome & Co	Plainwell Sanitarium1050
Campbell Soup Company1053	Poythress, Wm. P. & Co
Fisher Building	Purdue Frederick Company1010
Geigy Pharmaceuticals 1072, 1073, 1096, 1097	Robins, A. H. Company1079
Glenbrook Laboratories (Bayer)1049	Roche Laboratories1042, 1043, 1084, 1085
Hynson, Westcott & Dunning, Inc Cover III	Cover IV
Ingram Company, G. A 1090, 1099	Sandoz Pharmaceuticals1083
Lederle Laboratories1008, 1067, 1075	Searle, G. D. & Company1054, 1055
Lilly, Eli & Company1012	Smith, Kline & French Labs1089
Mallard, Inc	Stratton, Ben P. Agency1077
Medical Protective Company1101	Strasenburgh Laboratories1061
Merck, Sharp & Dohme1068, 1069, 1070	Stuart Company1091
Mercywood Hospital1095	Wyeth Laboratories 1046, 1047, 1062, 1063, 1093

* Specialized Service

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

MEDICAL PROTECTIVE COMPANY

FORT WAYNE INDIANA

Professional Protection Exclusively since 1899

DETROIT OFFICE: G. A. Triplett, R. K. Wind and J. K. Galloway, Representatives 27200 Lahser Road, Southfield 48075 Telephone: (Area Code 313) Elgin 3-4848 or 444-1439

GRAND RAPIDS OFFICE: G. J. Haworth, Representative 422 Federal Square Building, Grand Rapids 49502 Telephone: 616-454-4477

QQNOTES & QUOTES 99

BY HERB AUER, EXECUTIVE EDITOR

"The enthusiastic comments of students leaving the Health Careers Mobile testify to the effectiveness of the displays," so declares the Lake Odessa Wave after the Mobile had visited the Lake Odessa Fair. The newspaper also pointed out that "It is possible that positive commitment to a health career may result for many of the young people because of their exposure to the mobile displays and the reading materials offered." The article lauded the contributions of the Michigan Health Council, MSMS, and other cooperating organizations and foundations.

The AMA offers five booklets in a sex education series that MSMS members may wish to refer to teachers, parents, ministers, friends. Each booklet is available for 40 cents each from the AMA, 535 North Dearborn, Chicago 60610. The series includes "A Story About You" for children in grades 4, 5, and 6; "Finding Yourself" for junior high students, "Ap-



proaching Adulthood" for youths 16-20; "Parents' Responsibilities" for parents of pre-school and early-school-age children; and "Facts Aren't Enough" for parents who wish help in answering children's questions.

Greatest job conflicts occur in the upper-middle levels of management where workers with unfulfilled ambitions must supervise other employees, writes Robert L. Kahn, University of Michigan social psychologist, in the current issue of *Psychology Today* journal. Professor Kahn found that successful executives have fewer ulcers than blue-collar men down the line. He writes that to a large degree job status and health go hand-in-hand.

"Evidence linking together liquor-automobiles-death is overwhelming. The U.S. Department of Transportation has issued a re-



port to Congress which even diehard statisticians agree is a definitive indictment of drink-then-drive offenders. This landmark study concludes that the use of alcohol by drivers and pedestrians leads to some 25,000 deaths and a total of at least 800,000 crashes in the United States each year."

This statement is part of the "Alcoholocaust" booklet now available from Travelers Insurance, 1 Tower Square, Hartford, Connecticut, 06115.

People don't ask for facts in making up their minds, writes Robert K. Leavitt. "They would rather have one good, soul-satisfying emotion than a dozen facts."

Michigan producers have a very real stake in the continuing growth of world markets, reports the current issue of the Federal Reserve Bank of Chicago Business Conditions. Michigan and the 11 other midwest states account for more than 30 per cent of the nation's manufactured exports in

1966 (latest year that figures are available) and between 40 and 50 per cent of the agricultural exports.

Michigan ranks fifth in the nation in manufactured exports.

The speaker at the Hutzel Hospital Centennial pointed to one of the medical training problems. R. E. Tranquada, MD, medical director and associate dean, Los Angeles County, University of Southern California Medical Center, in part, declared.

"Unless hospitals can improve the allure of the teaching wards and eliminate the existing differences between the private wings and pavilions and the 'clinic' services, we shall find ourselves without patients to teach with. To some extent the newer teaching aids and automation may reduce the need for teaching patients, but the need will never be totally eliminated. Therefore, we must begin planning right now the mechanisms by which we may make our teaching services compete favorably with our present private services. The distinction will vanish."

A strong position that advertising in association journals should not be taxable has been taken by the American Society of Association Executives. ASAE Executive Vice President James P. Low, in opposition to the taxation of advertising income, stresses these points:

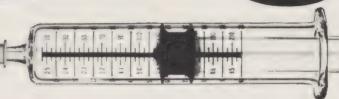
- (1) Advertising in association publications is selective and educational to the subscribers.
- (2) There is no unfair competition in association advertising in that the prestige of the organizations and their publications attract advertising rather than lower rates.
- (3) A journal or other publication must be considered as a whole and not bisected.

Baloney is flattery so thick it cannot be true, and blarney is flattery so thin we like it — F. J. Sheen.

BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)



BROMSULPHALEIN® IN A STERILE, DISPOSABLE, ECONOMICAL UNIT

The Bromsulphalein test is a convenient, sensitive, reliable test of liver function.

The precalibrated syringe contained in the BSP Disposable Unit makes weight calculations unnecessary, providing proper dosage regardless of patient-weight. Each unit contains complete directions for use, precautions and contraindications.

The all-inclusive BSP Disposable Unit provides economic unit dispensing.

Complete literature available on request.

HYNSON. **WESTCOTT & DUNNING, INC.**



Baltimore, Maryland 21201

(85204)



When disease is ruled out and psychic tension is implicated

Valium[®] (diazepam) helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma:

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation

or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, atàxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcitec states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



WI 292

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

OCTOBER 1969 • VOLUME 68 • NUMBER 20

No of the second

UNOFFICIAL PROCEEDINGS OF HOUSE OF DELEGATES ON PAGES 1105-1110

NOV 1 2 1969

HOUSE RE-ELECTS BLODGETT, BASS

Dr. Mason Installed; Dr. Hiscock New President-elect; Dr. Taylor Re-elected

The leaders of the Michigan State Medical Society, elected for 1969-70 by the House of Delegates, are:

President: Robert J. Mason, M.D., Birmingham
President-elect: Harold H. Hiscock, M.D., Flint
Speaker: James B. Blodgett, M.D., Detroit
Vice-speaker: Vernon V. Bass, M.D., Saginaw
Council Chairman: Ross V. Taylor, M.D.,
Jackson

Council Vice-chairman: Ralph R. Cooper, M.D., Detroit

The officers were installed, elected, or re-elected at the 1968 Annual Session of the MSMS House of Delegates in Detroit, along with others who were selected to serve on The MSMS Council or in the MSMS delegation to the AMA House of Delegates.

The MSMS House of Delegates, at its closing session Sept. 30, unanimously elected Doctor Hiscock as the president-elect. Doctor Hiscock, a graduate of Wayne State University School of Medicine, has practiced urology in Flint since 1930. He has been a member of The MSMS Council.

At that final session, the delegates re-elected Speaker Blodgett and Vice Speaker Bass for their third terms, and praised them for their excellent handling of the 1969 business meeting. Doctor Mason was installed as the new president at a special Delegates Dinner Sept. 30 to succeed James J. Lightbody, M.D., who completed his year as MSMS president.

When The MSMS Council reorganized on Sept. 30, the councilors re-elected Doctor Taylor chair-

man and Doctor Cooper vice-chairman. John J. Coury, M.D., was re-appointed chairman of the County Societies Standing Committee and Brooker L. Masters, M.D., was reappointed Publication Committee chairman, while John R. Pedden, M.D., and Sidney Adler, M.D., Detroit, were named new chairmen of the Education Liaison and Finance Committees, respectively.

Four delegates and four alternate delegates were re-elected for two-year terms in the AMA House of Delegates. All were unopposed, Returned as delegates were Otto K. Engelke, M.D., Ann Arbor; John R. Heidenreich, M.D., Daggett; Luther R. Leader, M.D., Royal Oak, and Robert E. Rice, M.D., Greenville. Re-elected to serve as alternates

THREE CONSECUTIVE PRESIDENTS of the Michigan State Medical Society posed together at the 1969 Annual Session at the Sheraton-Cadillac Hotel, Detroit. From left, they are James J. Lightbody, M.D., Detroit, immediate past president; Robert J. Mason, M.D., Birmingham, newlyinstalled president, and Bradley M. Harris, M.D., Ypsilanti, president in 1967-68.



MDPAC Workshop Nov. 8 At Lansing Has Speakers From AMA, Political Parties

Representatives from the Michigan Republican and Democratic parties, the AMA, the State Board of Education, and other state medical societies will be on the program for the annual Political Workshop of the Michigan Doctors Political Action Committee.

The workshop, scheduled Nov. 8 at the City Club, Jack Tar Hotel, Lansing, will begin with registration at 9:30 a.m. Jack M. Stack, M.D., Alma, is workshop chairman, while Donato F. Sarapo, M.D., Adrian, is MDPAC chairman.

Morning speakers for the workshop and their topics are William McLaughlin, chairman, Michigan Republican Party, "Party Organizations, Precinct to National, and How to Get In;" Mrs. Patti Knox, vice chairman, Michigan Democratic Party, "The Woman in Politics;" LeRoy Augenstein,

CONTINUED: NEW MSMS OFFICERS

are Paul T. Lahti, M.D., Royal Oak; Harold A. Furlong, M.D., Pontiac; John W. Moses, M.D., Detroit, and Bradley M. Harris, M.D., Ypsilanti.

Continuing to serve another year as Delegates are Sidney Adler, M.D., Detroit; George W. Slagle, M.D., Battle Creek; Donald N. Sweeny, Jr., M.D., Detroit, and Joseph A. Witter, M.D., Highland Park. Continuing alternate delegates are James C. Danforth, Jr., M.D., Detroit; John J. Coury, M.D., Port Huron; Marjorie Peebles-Meyers, M.D., Detroit, and Vernon V. Bass, M.D., Saginaw.

The delegates elected three new members of The MSMS Council. Robert M. Leitsch, M.D., Union City, representing the third district, to succeed Harvey C. Hansen, Battle Creek, who served nine years; Adam C. McClay, M.D., Traverse City, representing the ninth district to succeed Robert V. Daugharty, M.D., Cadillac, who also served nine years, and Robert C. Prophater, M.D., Bay City, representing the 10th district, to fill the unexpired term of Edward H. Rodda, M.D., Bay City, who served five years on The Council.

Returned to The Council were Sidney Adler, M.D., Detroit, First District; Ross V. Taylor, M.D., Jackson, Second District; Brooker L. Masters, M.D., Fremont, 11th District; J. Robert Franck, Jr., M.D., Wakefield, 13th District.

Former Immediate Past President Bradley M. Harris, M.D., Ypsilanti, completed a 21-year period of service with The Council.

Ph.D., member, State Board of Education, "The Importance of the Statewide Education Board Races;" Harold McClure, Michigan Republican National Committeeman, "Swing District Politics," and James Foristal, legislative representative for the AMA, Washington, D.C., "Report from Capitol Hill."

Speakers on the afternoon program will include a panel on "Politics, 1970," with State Reps. Robert Waldron and William Ryan, State Sen. Thomas Schweigert and James McNeeley, chairman, Democratic State Committee; Philip Thomsen, M.D., past president, Illinois Medical Political Action Committee, and past president, Illinois State Medical Society; State Sen. Coleman Young, Michigan Democratic National Committeeman, "The Minorities in Politics;" State Sen. Lorraine Beebe, "Women, Politics and Abortion Reform;" Frederick VanDuyne, M.D., chairman, Seventh Congressional District, "Physicians: Practice and Politics;" and a panel on "The Role of MDPAC and AMPAC in Primary and General Elections." with Mrs. Lee Ann Elliott, vice chairman, AM-PAC; James Imboden, AMPAC field service, Doctor Sarapo and M. A. Riley, MSMS legislative counsel.

SAMA STUDENTS AT MSU TO AID NIGERIA-BIAFRA WITH DRUG COLLECTION

In cooperation with a national Student American Medical Association project of Nigeria-Biafra Medical Relief, The Michigan State University SAMA chapter is collecting unused drugs and medical supplies from physicians in central and southern Michigan to send to the warring countries.

Endorsed by the MSU College of Human Medicine and the Michigan State Pharmaceutical Association, the students are contacting physicians and county medical societies in Ingham, Washtenaw, Genesee, Clinton, Calhoun, Jackson, Kent, Saginaw, Shiawasee, Livingston and Eaton Counties. They ask that physicians leave unwanted medical supplies with the pharmaceutical directors of their affiliated hospitals, to be picked up at frequent intervals by students with homes in the area.

The medical supplies will be stored at the MSU College of Human Medicine until enough are gathered for shipment to national SAMA-approved relief centers in Nigeria and Biafra.

THE PROCEEDINGS
WILL BE PRINTED IN
DECEMBER AS PART
OF MICHIGAN MEDICINE

Unofficial Summary of House Action



BY JAMES B. BLODGETT, M.D. SPEAKER OF THE MSMS HOUSE OF DELEGATES

The following summary report of the proceedings of the 104th (1969) House of Delegates of the Michigan State Medical Society is UNOFFICIAL.

It is designed to assist delegates in reporting to their medical societies prior to the publication of the official stenotyped record which is printed in Michigan Medicine, the Society's monthly journal.

One-hundred-sixty-six Delegates and 24 Section Delegates considered 88 resolutions, (a 23% increase over 1968) a 12-page comprehensive report of the past year's activities of The MSMS Council, 60 pages of material submitted by Michigan Medical Service, 42 MSMS and Council Committee reports, eight House of Delegates Committee reports, a complete balance sheet and comprehensive Treasurer's Report, and numerous other special reports.

The following decisions of the House as the legislative body of MSMS shape the policy and course of the Michigan State Medical Society for 1969-70.

MATTERS OF GENERAL MSMS BUSINESS

The House increased MSMS annual dues by \$25.00 per year, per member. (Ref. Rept. Ways and Means, p. 5)

The House commended Auxiliary for its effective educational, "Mobile Meals," AMA-ERF, legisla-

tive and World Medical Relief activities during 1969. (Ref. Rept. Council and Officers, p. 1)

The House determined to make available to interested groups a film dealing with drug dependence—marijuana. (Ref. Rept. Council and Officers, p. 2)

The House endorsed continued efforts to plan health programs for the disadvantaged in Michigan urban areas. (Ref. Rept. Council and Officers, p. 3)

The House changed the relative value for certain diagnostic laboratory services in the current RVS (tan book) in accordance with schedule appended to the Committee on RVS Annual Report for 1968-1969, except that pp. 8 & 9 of that appendix were not approved. (All tests in appendix are listed in the tan book under proper specialties except the BMR which has 5 units.) (Ref. Rept. Council and Officers, p. 4)

The House discontinued the designation of an annual "Outstanding Michigan Physician;" Certificates of Commendation for meritorious service will continue to be awarded. (amended Res. 1, Ref. Rept. Res., p. 1)

The House directed that The Council transmit information of its deliberations in as much detail as possible to the members of the House of Delegates. (amended Res. 39, Ref. Rept. Res., p. 1)

The House resolved that MSMS would join other state medical societies in aiding the American Medical Association in education programs dealing with the medical aspects of crime and delinquency. (amended Res. 68, Ref. Rept. Res., p. 2)

The House directed The Council to develop a



CERTIFICATE of HUMANITARIAN SERVICE from the American Medical Association was presented at opening House of Delegates ceremonies Sunday evening to Alfred B. Swanson, M.D., Grand Rapids, right, by AMA Executive Vice President Ernest B. Howard, M.D.

Continued: Unofficial Summary of House Action

medical socio-economic counseling service for itself, the county medical societies and individual members, to have among its functions consultation in the negotiation of contracts for provision of medical services. (Sub. for Res. 5, 43, 53, and 73, Ref. Rept. Res., p. 2) (See also item 7, County Medical Societies)

The House directed The Council to prepare to protect interests of patients and physicians in any proposed system of *national* health care. (amended Res. 88, suppl. Ref. Rept. Res.)

The House endorsed MSMS cooperation with recognized physical fitness and health programs. (amended Res. 23, Ref. Rept. Misc. Bus., p. 1)

In Bylaw changes, the Secretary and the Treasurer of MSMS were added to The Council's Executive Committee, and to limit to elected councilors those eligible to be selected Chairman, Vice Chairman, or Chairman of the major standing committees of The Council. (Ref. Rept. Const. & Bylaws, p. 3)

The Speaker of the House was directed to appoint a committee to study the method of nominating all elective officers of the House, including Delegates and Alternate Delegates to AMA. (Sub. Res. 13 as amended, Ref. Rept. Const. & Bylaws, p. 3)

The House encouraged medical school faculty members to join and participate in local county medical societies and attend meetings of the House of Delegates, and requested that Deans continue to be invited to all Council sessions. (amended Res. 22, Ref. Rept. Const. & Bylaws, pp. 3-4) (See also item 10, County Medical Societies)

The House amended Bylaws to exempt persons in post-graduate study or approved residencies from dues in MSMS if also exempted by the county medical society. (amended Res. 34, Ref. Rept. Const. & Bylaws, p. 4) (See also item 11, County Medical Societies)

The House directed Speaker to appoint an Ad Hoc Committee to study modus operandi for establishing a working relationship of Specialty Sections with the House of Delegates and report at the 1970 session. (amended Res. 80, Ref. Rept. Const. & Bylaws, p. 5)

The House approved transmitting to all members via Michigan Medicine a constitutional amendment for vote by the 1970 House, calling for nomination by either The Council or House of candidates for Secretary and Treasurer of MSMS and election by the House for three year terms on The Council. (Ref. Rept. Const. & Bylaws, p. 5) A proposed constitutional restatement of MSMS purposes will also be transmitted to all members via Michigan Medicine and be voted upon in 1970.

The House resolved to develop and offer, as a public service, a standardized physical exam for all colleges and universities. (Res. 3 as amended, Ref. Rept. Public & Pro. Rel., p. 1)

The House directed that MSMS urge the State Board of Education and the Department of Public Health to require every school to have an "athletic medicine unit" and comply with the provisions of Res. 56, as amended. (Res. 56 as amended, Ref. Rept. Public & Pro. Rel., p. 1)

The House asked all medical schools in Michigan to train Athletic Health Coordinators (trainers). Res. 56 as amended is to be forwarded to the Governor and Legislature of Michigan and other specified authorities, (Res. 56 as amended, Ref. Rept. Public & Pro. Rel., p. 1)

The House directed The Council to survey all MSMS members (except for those in Wayne County, already surveyed) on problem areas related to professional liability insurance coverage. (Ref. Rept. Public & Pro. Rel., p. 2)

The House went on record opposing the "contingency fee" system in malpractice cases. (Res. 10 as amended, Ref. Rept. Public & Pro. Rel., p. 2)

The House urged University of Michigan and Michigan State University to follow Wayne State University's lead in providing seminars on "Law and Medicine." (Res. 55)

The House requested investigation of sources of

funds to help defray costs of MSMS postgraduate education programs, an evaluation of the Society's newspaper/radio series, and a bi-annual publication of an MSMS directory (with corrective sheets annually). (Ref. Rept. Ways and Means, pp. 1-2)

The House asked for increased contact between councilors and component societies, with the necessity for Councilor Conferences to be evaluated by The Council, MSMS. (Ref. Rept. Ways and Means, p. 2) (see also item 12, County Medical Societies)

The House directed a study (cost not to exceed \$5,000) of MSMS administrative structure with a report to the 1970 House of Delegates. (Ref. Rept. Ways and Means, p. 5)

MATTERS PERTAINING TO LEGISLATION AND GOVERNMENT

The House stated that governmental participation in medical care should be limited to a contribution to financing according to the individual recipient's needs as determined by his economic circumstances. (Sub. Res. 70, Ref. Rept. Misc. Bus., p. 3)

The House recommended that the medical profession request opportunity to participate in negotiations for malpractice insurance rate increase requests submitted to the Department of Insurance; that malpractice insurers be asked not to cancel licensed MSMS members solely because of their age or number of claims; and that each MSMS Annual Scientific Session have a program dealing with professional liability. (Ref. Rept. Public & Pro. Rel., p. 2)

The House reiterated vigorous support for passage of professional liability laws (S.B. 400, 401, 402 and 784) by the 1970 State Legislature. (Ref. Rept. Public & Pro. Rel., p. 2) and (Res. 63 as amended, Ref. Rept. State & Fed. Leg., p. 4)

The House requested consultation between MSMS and Michigan Insurance Commissioner on pertinent matters affecting professional liability cost and coverage. (Ref. Rept. Public & Pro. Rel., p. 2)

The House determined to implement a system of utilizing physician members in legislative contact, in lieu of the employing of a second full-time legislative agent, for a one-year trial basis with report to the 1970 House of the success of such a method. (Ref. Rept. Ways and Means, p. 3)

The House directed a study of the concept of "county health authorities" (25% of the board to be licensed physicians) to replace public health

committees of boards of supervisors. (Res. 4 as amended, Ref. Rept. State & Fed. Leg., p. 1)

The House reaffirmed policy that the Michigan Criminal Code should not apply to abortions performed in licensed and accredited hospitals by licensed MDs and DOs. (Res. 14 as amended, Ref. Rept. State & Fed. Leg., p. 2)

The House favored improved legislation to insure school bus safety. (Res. 30)

The House asked for inclusion of all compulsory child physical exams as a Medicaid benefit. (Res. 35 as amended, Ref. Rept. State & Fed. Leg., p. 2)

The House requested introduction of legislation calling for two attendants on all ambulances and increased ambulance attendant training in cardio-pulmonary resuscitation. (Res. 40)

The House directed that the Governor be asked to disapprove mandatory use of Hill-Burton criteria and/or the Hill-Burton state plan by areawide comprehensive health planning councils. (Res. 46)

The House determined to ask the Governor of Michigan to make the State Comprehensive Health Planning Advisory Council the appeal board for decisions made by area-wide health planning councils and the Michigan State Comprehensive Health Planning Commission itself. (Res. 47)

The House directed that MSMS cooperate with the Michigan Hospital Association in preparing, introducing and urging an amendment to correct certain discriminations against physicians and women as members on county hospital boards of trustees. (Res. 48 as amended, Ref. Rept. Public & Pro. Rel., p. 3)

The House stated as a matter of principle that the State Legislature should provide more funds for institutions to rehabilitate juvenile delinquents. (Res. 62)

The House determined to support any legislation calling for funds to treat abusers of drugs, directing that its resolution in this regard be given wide distribution. (Res. 65 as amended, Ref. Rept. State & Fed. Leg., p. 4)

The House directed the MSMS to take the Title 18 "fee freeze" to court to determine the legality of this action. (Res. 74)

The House request The Council to assign a committee to prepare a "position paper" on the matter of the Food and Drug Administration exerting undue influence on medical practice. This position paper is to support an MSMS resolution

MORE ARTICLES AND PHOTOS OF 1969 ANNUAL SESSION WILL APPEAR IN NOVEMBER ISSUE OF MICHIGAN MEDICINE



New MSMS President-elect Harold H. Hiscock, M.D.

Continued: Unofficial Summary of House Action

to be introduced at the AMA House in December, 1969. (Ref. Rept. State & Fed. Leg., pp. 4-5)

MATTERS DEALING WITH PARAMEDICAL AND ALLIED SUBJECTS

The House commended the Medical Assistants for their service and education programs and urge the MSMAS to continue to exert leadership in the AAMS. (Ref. Rept. Council and Officers, p. 1)

The House urged continued study of the training of "assistant physicians" in Michigan. (Ref. Rept. Council and Officers, p. 2)

The House disapproved of registered nurses from the Department of Public Health reviewing staff medical records and medical committee functions in hospitals. (Ref. Rept. Council and Officers, p. 3)

The House added doctors of osteopathy to the Bylaws section setting forth those who may be active members of MSMS. (Ref. Rept. Const. & Bylaws, p. 1)

The House favored amalgamation between MDs and DOs as "being in the best interest of the future of medical practice and therefore the health of all." (Res. 19, Ref. Rept. Public & Pro. Rel., p. 1)

The House reaffirmed position that chiropractic is an "unproven cult;" decried chiropractors' unfounded advertising claims. (Res. 17 as amended, Ref. Rept. Public & Pro. Rel., p. 2)

MATTERS PERTAINING TO BLUE SHIELD AND PREPAYMENT PLANS

The House asked Michigan Medical Service to institute an experimental pilot program to determine feasibility of paying physicians' charges as submitted. (Ref. Rept. Health Ins. & Med. Serv., p. 1)

The House requested Michigan Medical Service to immediately withdraw its "over the screen" letter and in the future simply include with the payment to the subscriber the following statement: "This payment represents the financial obligation of Blue Shield for this service." (Sub. Res. for 2, 9, 11, 21, 29, and 67; Ref. Rept. Health Ins. & Med. Serv., pp. 2-3)

The House again requested Michigan Medical Service to devise a way of informing subscribers who do not pay their own premiums of the amount attributable to Michigan Medical Service and the amount which is Michigan Hospital Service. (Sub. Res. 12; Ref. Rept. Health Ins. & Med. Serv., pp. 2-3)

The House requested MMS to provide a benefit for the care of newborns throughout the period of hospitalization regardless of who attended at delivery. (Res. 15, corrected, Ref. Rept. Health Ins. & Med. Serv., p. 3)

The House clarified a 1968 resolution and requested Michigan Medical Service to pay for major nerve block, spinal, saddle, caudal and local intravascular (as used in the extremeties) anesthesia when rendered by a physician along with obstetrical or surgical procedures, regardless of the availability of an anesthesiologist. (Res. 16 as amended, Ref. Rept. Health Ins. & Med. Serv., p. 3)

The House requested Michigan Medical Service to restudy its present socio-economic areas used to ascertain "prevailing fees," to insure that these are equitable. (Sub. Res. for 24, 26, Ref. Rept. Health Ins. & Med. Serv., p. 3)

The House requested Michigan Medical Service to conform with the following resolution adopted by the AMA in July, 1969: "RESOLVED: That at the time of conception of each program, the terms 'usual, customary or reasonable' be properly defined and agreed upon by the physicians, the beneficiaries, and the insurance carriers as developed by local determination so far as a physician's participation is concerned, and be it further RESOLVED: That any reference to 'paid-in-full' coverage, clearly identify those services which are indeed covered on a 'paid-in-full' basis, and also identify the circumstances under which those services must be rendered." (Res. 28)

The House reaffirmed MSMS strong support of individual case participation in Blue Shield. (Res. 32)

The House directed a full Council study of the "favorable and unfavorable ramifications of the feasibility" of MSMS discontinuing its historical relationship with MMS. Report is to be made to the 1970 House. (Sub. Res. for 44, 64, and 81; Ref. Rept. Health Ins. & Med. Serv., p. 4)

The House requested Michigan Medical Service

to "change its policy of dunning physicians when accounts have been closed and MMS later determines an additional amount is due through error and direct any future action for recovery of such fees to the subscriber." (Res. 49)

The House requested that Michigan Medical Service Board specifically invite MSMS representatives to each Blue Shield board meeting, sending a schedule of all meetings and the full "blue book" (agenda and back-up) to MSMS sufficiently in advance for adequate study. (Sub. Res. 66 as amended, Ref. Rept. Health Ins. & Med. Serv., p. 5)

The House requested Michigan Medical Service to immediately supply all MSMS members with all pertinent details of the new MMS drug service program. (Sub. Res. for 82 & 83, Ref. Rept. Health Ins. & Med. Serv., pp. 5-6)

The House directed that in future each Councilor of MSMS and each County Medical Society (if it desires) will submit names of candidates for the Blue Shield Board to the nominating committee. This committee is to be appointed and is to make the names of candidates and their qualifications available to the House earlier than heretofore. (Sub. Res. 84, Ref. Rept. Health Ins. & Med. Serv., p. 6)

The House requested MMS to remove the present limit of two consecutive three-year terms for physician board members, and directed MSMS to provide adequate staff services for physician Michigan Medical Service board members. (Sub. Res. 85 as amended)

The House directed The MSMS Council to prepare and distribute to all Delegates before the 1970 session a pamphlet containing the Constitution and Bylaws of MMS and all associated documents, including the Consent Judgment of May 15, 1963. (Res. 86 as amended, Ref. Rept. Health Ins. & Med. Serv., p. 6)

MATTERS PERTAINING TO COUNTY MEDICAL SOCIETIES

The House urged each physician and county medical society to take as full an active part as possible in local comprehensive health care planning. (Ref. Rept. Council and Officers, p. 2; amended Res. 45, Ref. Rept. Res., p. 2)

The House stated that all county medical societies should have local emergency and disaster care committees constructed under guidelines available from the MSMS. (Ref. Rept. Council and Officers, p. 2)

The House approved the Michigan Department of Public Health vision screening program for preschool children made mandatory commencing September, 1970. (Ref. Rept. Council and Officers, p. 2)

The House requested the State Board of Educa-

tion to recommend to all local school boards that where no local school health committee exists every school board should have a physician consultant. (Ref. Rept. Council and Officers, p. 5)

The House urged that local communities attempt to improve ambulance service, if necessary through application for fedéral funds. There should be a communications system between ambulances and hospitals. (Ref. Rept. Council and Officers, p. 5)

The House urged local county medical society leaders to confer regularly with community groups to exchange problems and develop joint project possibilities. (Ref. Rept. Council and Officers, p. 6)

The House directed The Council to develop a medical socio-economic counseling service for itself, the county medical societies and individual members, to have among its functions consultation with negotiators of contracts for provision of medical services. (Sub. for Res. 5, 43, 53, and 73, Ref. Rept. Res., p. 2)

The House charged each county medical society with the responsibility of indoctrination of each new member. Medical schools will be encouraged to inform students of the organizational structure of medicine, and The Council, MSMS will develop a membership certificate to be issued to each new member on first payment of dues. (Res. 27 as amended, Ref. Rept. Misc. Bus., p. 2)

The House amended the Bylaws to permit a member of the Judicial Commission to also serve on his county medical society board or ethics, grievances or mediation committees; he must disqualify himself on local issues, however. (Ref. Rept. Council and Bylaws, p. 2)

The House encouraged medical school faculty members to join and participate in local county medical societies and attend meetings of the House of Delegates, and requested that Deans continue to be invited to all Council sessions. (Res. 22 as amended, Ref. Rept. Const. and Bylaws, pp. 3-4) (See also item 14, Gen. Bus.)

The House amended Bylaws to exempt persons in post-graduate study or approved residencies from dues in MSMS if also exempted by the county medical society. (Res. 34 as amended, Ref. Rept. Const. and Bylaws, p. 4) (See also item 15, Gen. Bus.)

The House asked for increased contact between councilors and component societies, with the necessity for Councilor Conferences to be evaluated by The Council, MSMS. (Ref. Rept. Ways and Means, p. 2) (See also item 25, General Business)

MATTERS PERTAINING TO COMMITTEES

The House stated that all county medical societies should have local emergency and disaster care committees constructed along guidelines available



Chairmen of the Standing Committees of the MSMS Council posed following their election at the 1969 MSMS Annual Session with, far left, Ross V. Taylor, M.D., Jackson, re-named Council chairman, and far right, Ralph R. Cooper, M.D., Detroit, re-named Council vice chairman. Others, from left, are John J. Coury, M.D., Port Huron, County Societies Committee chairman, Brooker L. Masters, M.D., Fremont, Publication Committee chairman, both re-elected, and Sidney Adler, M.D., Detroit, newly-elected Finance Committee chairman. Not pictured is John R. Pedden, M.D., Grand Rapids, newly-elected chairman of the Education Liaison Committee.

Continued: Unofficial Summary of House Action

from MSMS. (Ref. Rept. Council and Officers, p. 2) (See also item 2, County Medical Societies)

The House urged The Council to revise and combine committee assignments if indicated so as to avoid duplication of effort. (Ref. Rept. Council and Officers, p. 6)

The House directed the Public Health Committee to work with the Michigan Department of Public Health in implementing and expediting the use of voter-approved funds for water pollution control programs. (Res. 2 as amended, Ref. Rept. Res., p. 1)

The House directed the Educational Liaison Committee and The Council to encourage adequate emphasis by medical schools on instruction in General Practice. (Sub. Res. 41, Ref. Rept. Misc. Bus., p. 2)

The House redesignated the Committee on Maternal Health as the Committee on Maternal and Perinatal Health. (Ref. Rept. Council and Bylaws, p. 2)

The House directed that an appropriate commit-

tee study the Uniform Arbitration Act and determine its utility with respect to professional liability problems. (Ref. Rept. Public & Pro. Rel., p. 2)

The House asked that an appropriate committee seek to develop programs to encourage new medical graduates to serve two years in an area of acute need in Michigan. (Res. 8 as amended)

The House requested the Committee on Professional Liability Insurance to study the feasibility of creating MSMS machinery for medical defense (alleged malpractice). (Res. 51, Ref. Rept. Public & Pro. Rel., p. 2)

The House directed The Council to request the Maternal and Perinatal Committee to report within three months (by January 1, 1970) a concise position statement on "Teaching Sex Education." (Ref. Rept. State & Fed. Leg., p. 3, reference: Res. 42)

The House requested the Committee on Governmental Medical Care Programs to make every effort to obtain improved payment for physician services from the Veteran's Administration, based on the usual, customary and reasonable fee concept. (Res. 78 as amended, Ref. Rept. State & Fed. Leg., p. 4)

Second Class Postage Paid at East Lansing, Mich. and at additional mailing offices.

Michigan Medicine

MICHIGAN STATE MEDICAL SOCIETY

Published semi-monthly, Trimonthly in November and December; 26 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, \$9.00. Printed in USA. All communications should be addressed to the Publications Communitee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. © 1969 Michigan State Medical Society. Phone: Area Code 517, 337-1351.

NLM-MX2 BOX Q BETHESDA MARYLAND

20014



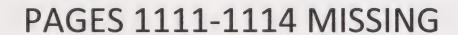
INSIDE: CORONARY CARE UNITS, THE MANY SIDES OF PROFESSIONAL INCORPORATION, EDITORIAL ON COMPULSORY HEALTH INSURANCE

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

NOVEMBER 1969 • VOLUME 68 • NUMBER 21





MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

NOVEMBER 1969 • VOLUME 68 • NUMBER 21

Cecil Corley, M.D., Jackson, Named 'Physician of the Year'

Cecil Corley, M.D., Jackson internist and community leader, is "Michigan's Outstanding Physician of the Year" — selected by the Michigan State Medical Society House of Delegates in their Annual Session in Detroit.

The House of Delegates approved the recommendation of a special selections committee to honor Doctor Corley, who has practiced in Jackson since 1921. Doctor Corley received a special citation at a dinner program in the Sheraton-Cadillac Hotel.

The citation reads: "To Cecil Corley, M.D., Jackson, for his distinguished career as a physician and public servant. Doctor Corley, a graduate of the University of Michigan Medical School, has been a dedicated general practitioner and internist in Jackson for 47 years, and still continues in active practice at the age of 75. He established the first clinical laboratory in Jackson in 1921 and is credited with using the first oxygen tent and therapy, and the first intermittent positive pressure therapy. Doctor Corley has earned a reputation as an accomplished and compassionate clinician, skilled in recognizing disease and in providing the most sophisticated care. He has a perpetual interest in continuing medical education. Doctor Corley has the complete respect of the citizens of Jackson, where he has served the community as a former member of the board of education for 11 years, including four years as the president. Doctor Corley also has been active in several medical organizations dealing with tuberculosis and other health concerns; and he formerly served on the Michigan State Board of Registration in Medicine. Doctor Corley is a truly professional, able, skillful physician and a credit indeed to the medical profession."

State-Supported D.O. School Goes to MSU

On October 29, the State Board of Education announced its decision to assign a state-supported college of osteopathy to Michigan State University. (Further details will appear in the November NEWS EXTRA. The October 29 announcement came as this issue of MICHIGAN MEDICINE was coming off the presses.)

The affiliation is not effective until it has been accepted by the MSU Board of Trustees, which has until January 1, 1970, to do so. If the board accepts the affiliation, it will mean that for the first time osteopathy is to be taught as a university discipline and at a public institution.

A HIGH POINT of the 1969 MSMS House of Delegates meeting in Detroit Sept. 28-Oct. 2 was the naming of Michigan's Outstanding Physician of the Year. Cecil Corley, M.D., center, Jackson internist and community leader for nearly 50 years, received the honor and a framed certificate from James B. Blodgett, M.D., Royal Oak, left, speaker of the MSMS House of Delegates, and Ross V. Taylor, M.D., Jackson, chairman of The MSMS Council.



Doctor Furlong



Doctor Jack



Doctor Kerlikowske

Certificates of Commendation Honor Six Michigan Physicians

Six outstanding Michigan physicians were recognized by their colleagues at the MSMS Annual Session for their fine contributions to their communities.

Receiving framed and inscribed MSMS Certificates of Commendation during ceremonies before the MSMS House of Delegates meeting were Harold A. Furlong, M.D., Pontiac; W. W. Jack, M.D., Grand Rapids; Albert C. Kerlikowske, M.D., Ann Arbor; Robert C. Prophater, M.D., Bay City; Arthur L. Tuuri, M.D., Flint, and C. Mark Vasu, M.D., Grand Rap-



Doctor Prophater



Doctor Tuuri

The wording of their certificates, presented by James B. Blodgett, M.D., Royal Oak, speaker of the MSMS House, follows:

Harold A. Furlong, MD, Pontiac: "In recognition of an outstanding career as an obstetrician and gynecologist in Pontiac and as the moving force in the establishment of the Pontiac Creative Arts Association; and also in grateful appreciation to this distinguished American who holds the Congressional Medal of Honor for heroism in battle."

W. W. Jack, MD, Grand Rapids: "In recognition of dedicated service to Michigan mothers and children through long leadership with the MSMS Committee on Maternal Health, and specifically with such projects as the Annual Michigan Conference on Maternal and Perinatal Welfare, Michigan Perinatal Study, and others."

Albert C. Kerlikowske, MD, Ann Arbor: "In recognition of 24 years of effective administration of the University Hospital in Ann Arbor where he helped blend outstanding programs in patient care, teaching, and research; and in grateful appreciation for a total of 45 years of dedicated service to the fast-expanding University Hospital before retiring this year."

Robert C. Prophater, MD, Bay City: "In recognition of inspiring Continued on Page 1118



Doctor Vasu

New Bibliography Service Offered To Health Team

Michigan physicians may obtain an extensive bibliography on any scientific topic of their choice by using a relatively new, free, service with headquarters in Ann Arbor.

The Regional MEDLARS (Medical Literature Analysis and Retrieval System) Center, run by the National Library of Medicine on a computer basis, was established nearly two years ago at the University of Michigan to serve the needs of the health science community of the State of Michigan.

The total MEDLARS system contains more than 1,000,000 articles from over 2,300 journals in the health fields. A more detailed article will follow in the December issue of Michigan Medicine.



The Public Forum on Diabetes at the Ford Auditorium was the only affiliated Annual Session activity for the general public, and more than 2,100 persons attended the program at the Ford Auditorium on October 2. The project, sponsored by MSMS, the Wayne County Medical Society, the Michigan Diabetes Association and the Detroit News, featured talks by medical experts, free blood-screening tests, and display tables of many helpful materials.

MSMS Members Contribute to Medical Schools

The deans of Michigan's three medical schools stepped forward one at a time to receive funds totaling \$20,141 from MSMS Immediate Past President James J. Lightbody, M.D., during House of Delegate ceremonies at the 1969 MSMS Annual Session.

The funds, representing contributions made by Michigan doctors to the AMA's Educational Research Fund, were designated for each of the Universities by the donors. They also included a share of the undesignated funds received from AMA members during the calendar year of 1968.

"For many years the Michigan State Medical Society has supported the efforts of the AMA-ERF to assist our many medical schools," said Doctor Lightbody on making

the presentations. "We have urged physicians and interested business firms to make contributions and we appreciate the fine work of the State Woman's Auxiliary and its many local units in raising funds."

The check to The University of Michigan totaled \$11,470; to Wayne State University, \$6,997, and to Michigan State University, \$1,674.



William N. Hubbard, Jr., M.D. University of Michigan



Ernest W. Gardner, M.D. Wayne State University



Andrew D. Hunt, Jr., M.D. Michigan State University

Former Dean Furstenberg Dies

Albert C. Furstenberg, M.D., Ann Arbor, former dean of the University of Michigan Medical School, died Oct. 23 at the age of 79.

Dean of the U-M Medical School from 1935 to 1959, Doctor Furstenberg turned the medical school into the largest and one of the foremost medical research centers in the country.

William N. Hubbard, Jr., M.D., current dean of the school, said of his predecessor, "In his many years of service, Doctor Furstenberg was a great physician, teacher and dean—three roles that demand full effort of most men. He presided with great distinction as dean of the Medical School through the crucial decades surrounding World War II, not only meeting those problems with a touch of greatness, but setting a true course for the future. Much of the best of the medical center reflects his life and work."

Doctor Furstenberg was graduated from the U-M Medical School in 1915 and was a specialist in otolaryngology. He was in pri-

STUDY AND FOOTBALL ON NOV. 22 AGENDA

The Michigan Heart Association is sponsoring the first of a planned annual series of "Study and Football Days" Nov. 22 in Ann Arbor. Park W. Willis, III, M.D., director, Heart Section, U-M Medical Center, has planned cardiovascular classes from 9 to 11:45 a.m., a buffet lunch and transportation by bus to the football stadium, where the U-M will play Ohio State. The fee is \$25, with special \$9 tickets available for spouses. Future Study and Football Days for Doctors will be alternated between Michigan universities.

vate practice over 50 years, and went back to his specialty after retirement at 69.

Doctor Furstenberg was a member of the American Academy of Ophthalmology and Otological Society, the American Otological Society, the American Laryngological Society and the American Otological, Rhinological and Laryngological Society, Inc.

SIX PHYSICIANS COMMENDED

Concluded from Page 1116

civic service in Bay City where he serves as a member of the City Commission, as the president of the Chamber of Commerce, and as an enthusiastic leader for many community and political organizations and projects."

Arthur L. Tuuri, MD, Flint: "In recognition of a distinguished career as a pediatrician serving the children of Flint and Michigan, and especially for creative leadership as the director of the Mott Children's Health Center; and also for dedicated service to Michigan organizations concerned about special education, cystic fibrosis, hemophilia, and crippled children and adults."

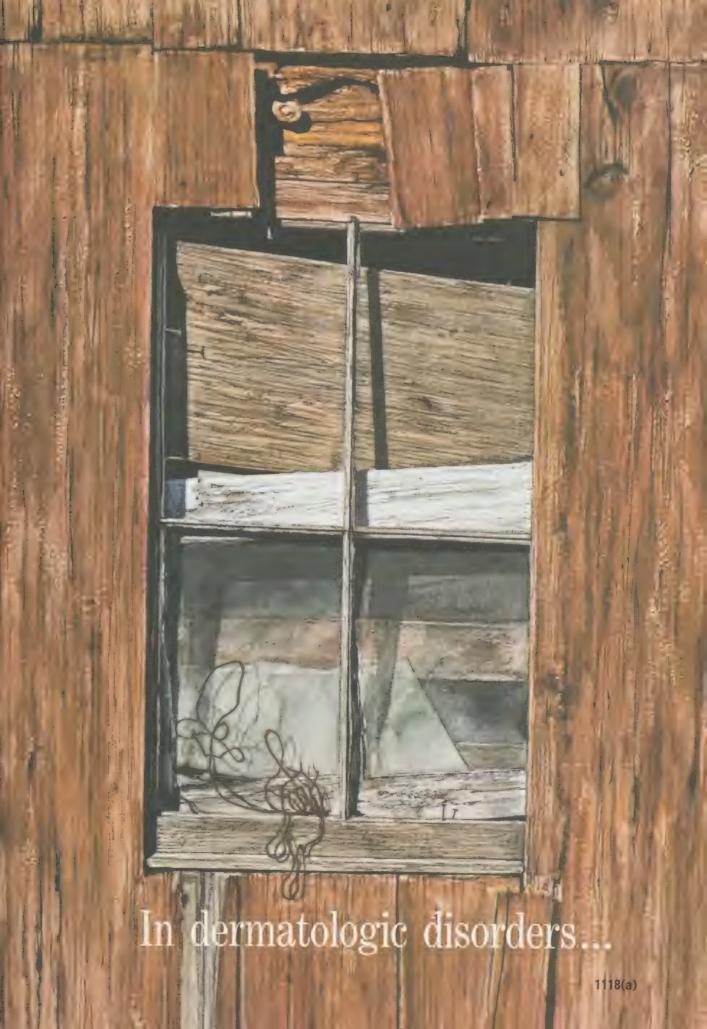
C. Mark Vasu, MD, Grand Rapids: "In recognition of inspired medical leadership in creating and expanding emergency medical care training programs for police, firemen and ambulance personnel in Kent County; and for other efforts to upgrade emergency medical services."

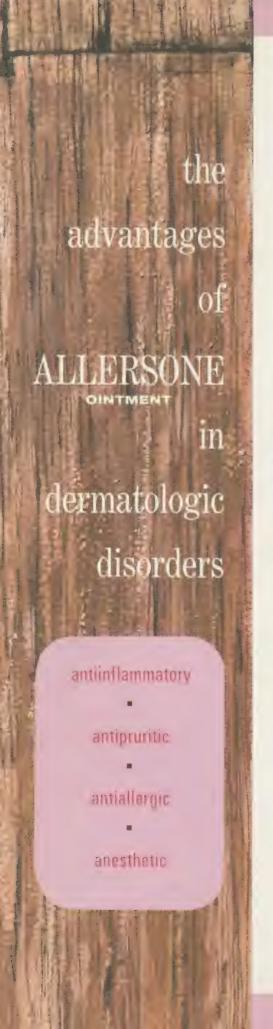
Representatives from many health fields organizations across the state watched Governor William Milliken sign the 1969 Michigan Community Health declaration.

Pictured from left to right are: Hugh W. Brenneman, Executive Director, MSMS; John A. Doherty, Executive Secretary, MHC; Mrs. Chastine Mangelsdorf, Health Careers Chairman, State Woman's Auxiliary; Mrs. Evelyn (Milton R.) Palmer, Medical Careers Co-ordinator, Detroit Public Schools; Ralph T. Wills, Community Relations Director, MSMS; John Diebel, Public Relations Department, Michigan Blue Cross/Blue

Shield; Milton R. Palmer, MD, Chairman, Talent Research Committee, Detroit Medical Society; Mrs. Helen (Hugh W.) Brenneman, Executive Secretary, Michigan Association of the Professions; Lynn Cook, President, Michigan State Pharmaceutical Association; Elizabeth Wheeler, Ph.D., Health Chairman, Michigan Congress of Parents and Teachers; Mrs. Kay Singer, Detroit Commission on Children and Youth; Kenneth H. Johnson, MD, Secretary, MSMS; E. Gifford Upjohn, MD, President, MHC; James D. Fryfogle, President, Wayne County Medical Society; John P. Hyde, Coordinator Health Manpower, MHC.







IN THE MANAGEMENT of common dermatologic disorders, ALLERSONE provides more than symptomatic relief for your frustrated patient. Because ALLERSONE combines the antiinflammatory, antiallergic and antipruritic action of hydrocortisone with the anesthetic effect of diperodon HCl, it can make a worthwhile contribution to your therapeutic regimen.

ALLERSONE has long provided safe, effective and economical therapy for the anxious patient plagued by dermatologic problems. In addition, it is greaseless, odorless, colorless, as well as washable; thereby assuring a high degree of cosmetic acceptance.

ALLERSONE

OINTMENT

for effective topical management

COMPOSITION: Representing: Hydrocortisone 0.5%; Diperodon Hydrochloride 0.5%; Calamine 2.5%; Zinc Oxide 2.5% in a water-washable base containing sodium lauryl sulfate, propylene glycol, cetyl alcohol, white petrolatum, methylparaben and propylparaben as preservatives and water.

INDICATIONS: Antiinflammatory, antipruritic, and antiallergic preparation with local anesthetic for use in the treatment of atopic dermatitis, dermatitis venenata or contact dermatitis as ivy or oak poisoning, pruritis ani and vulvae (anogenital pruritus), certain allergic skin diseases as infantile eczema, also chronic eczematoid otitis externa, neurodermatitides, intertrigo, as chafing of opposing skin surfaces as on thighs, axilla and below breasts.

ACTION: Hydrocortisone exhibits marked antiinflammatory activity when applied topically to the skin. It is ameliorative in pruritic, allergic and atopic skin lesions. Diperodon hydrochloride is a surface anesthetic, while the calamine and zinc oxide powders are well-known for their mild astringent and protective actions. The remaining ingredients comprise the water-washable base.

DOSAGE AND ADMINISTRATION: Distribute a small amount by gentle application over affected area, two or three times a day; frequency of application to be reduced with improvement.

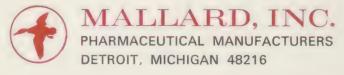
CONTRAINDICATIONS: Do not apply in the presence of herpes simplex of the eye, chickenpox or other viral diseases or skin tuberculosis; in the presence of a coexisting bacterial infection, an antibacterial agent should be used concurrently.

PRECAUTIONS: In rare instances local sensitivity reactions might occur. The safety of the use of topical steroid preparations during pregnancy has not been fully established. Therefore, they should not be used extensively on pregnant patients, in large amounts or for prolonged periods of time.

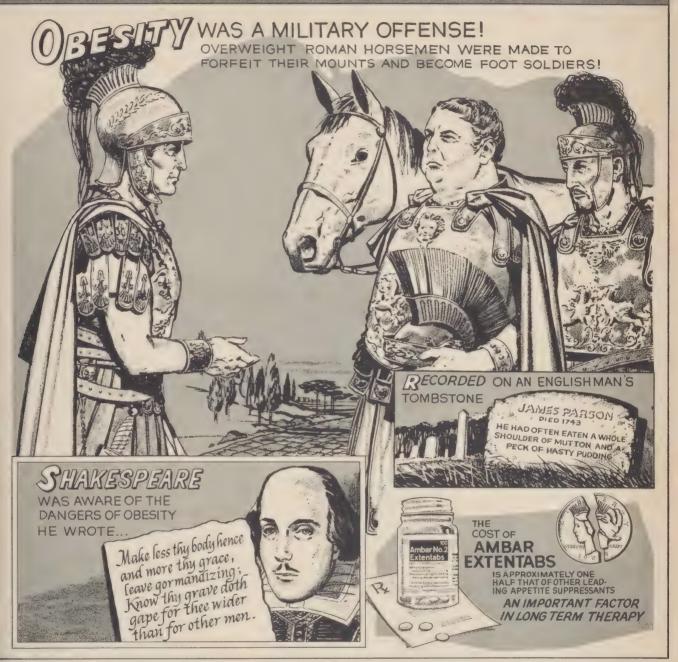
ADVANTAGES: Contains a local anesthetic which quickly ameliorates pain —while hydrocortisone reduces inflammation—in a water-washable vehicle —no desquamation from fats.

CAUTION: Federal law prohibits dispensing without prescription.

HOW SUPPLIED: 0.90 Allersone, pink ointment, available in 15 Gm. tubes and in pound jars.



The AMBAR® OF ODESITY Oddities



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Pheno-

barbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

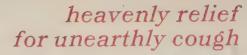
AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming). BRIEF SUMMARY/Indications: Ambar suppresses appetite and helps offset emotional reactions to dieting. Contraindications: Hypersensitivity to barbiturates or sympathomimetics; patients with advanced

renal or hepatic disease. Precautions: Administer with caution in the presence of cardiovascular disease or hypertension.

Side Effects: Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, A-H-ROBINS RICHMOND, VA. 23220



Benylin EXPECTORANT

Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate: 2 grains chloroform; 1/10 grain menthol; and 5% alcohol. An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take. PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT. ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur. PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal. Parke, Davis & Company Detroit, Michigan 48232

ASTRONAU

1118(d)

PARKE-DAVIS

410R69



ROBERT J. MASON, M.D. PRESIDENT, 1969-70

Wrong Choices Versus Good Health Habits

Doctors are deeply concerned about the many voluntary actions taken by people which affect their health and lives. While we work to improve the chances for a longer, fuller life by reducing infant mortality, by trying to curb further tuberculous, by urging Pap Tests to reverse uterine cancer; — people continue to make poor health choices every day.

The number of deaths in Michigan and the nation continue to climb every year because of motor vehicle accidents, lung cancer and cirrhosis of the liver. These are all related directly to voluntary actions by our fellow citizens.

As physicians we each must continue every day to urge good health habits. We must communicate more effectively to explain why certain good health practices are important — why people must control their weight, why young people should not start smoking, why we all should develop *positive* thinking.

HAND-IN-HAND with this we must continue to set good examples. We all have heard patients comment that some doctor friend they know smokes excessively, that some doctor in the neighborhood doesn't use his seat belt, etc.

With the advances in medical care, it is inconceivable that so many people make the wrong choices and so many do not adopt good sensible health habits.

Irresponsible drivers — often while under the influence of liquor — cause many unnecessary auto accidents, injuries and deaths.

Heavy smoking, we know, increases the dangers of lung cancer. And we are especially concerned about Michigan studies this past year by the Michigan Youth Commission that discovered growing smoking habits by children in the fifth grade.

Medical science knows too that intemperate drinking leads to cirrhosis.

There are so many opportunities for our MSMS committees in the several scientific areas — such as Cancer, Respiratory Diseases, Public Health-Mental Health — to work with our Public Relations Committee, Publication Committee and others to jointly develop positive campaigns to reach the schools, the parents, the workers, the public. The same combinations through communication and cooperation can be developed in every county medical society — and perhaps by many of the hospital medical staffs too.

WE CANNOT become discouraged. We must continue to seek out new ways. We must challenge more of the younger physicians to become active in these projects because they have rapport with the millions of young people in our society today.

The responsibility to provide authentic information about good health practices is clearly ours in the medical profession and ours in our organized medical societies.





growth during broad-spectrum therapy-the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN -the broad-spectrum therapy that prevents monilial overgrowth.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from ery thema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Con-

measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system-anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin-maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney-rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare) Hypersensitivity reactions-urticaria, angioneurotic edema, anaphylaxi Teeth-dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the dru during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyn crasy occurs, discontinue medication and institute appropriate therap Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should b given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, food and some dairy products. Treatment of streptococcal infections shoul

LEDERLE LABORATORIES, A Division of American Cyanamid Companion Pearl River, New York

continue for 10 days, even though symptoms have subsided.

INFORMATION

FOR CONTRIBUTORS

- 1. Address scientific manuscripts to the Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.
- 2. Submit original, double-spaced typewritten copy and two carbon copies or photo copies on letter size ($8\frac{1}{2} \times 11$ inch) paper.
- 3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits
- 4. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide a latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not
- 5. Illustrations should be submitted in the form of glossy prints or original sketches from which cuts, or plates, will be made by Michigan Medicine. Michigan Medicine will pay the first \$25 of the engraving bill, and the authors shall pay the balance. An estimate of the cost will be submitted to authors before cuts are ordered.
- 6. References will ordinarily be limited to seven in number. Exceptions may occasionally be made.
- 7. Contributors will be notified as soon as practical if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.
- 8. Articles should ordinarily be less than four printed pages in length (3000 words).
- 9. References should conform to Cumulative Index Medicus, including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.
- 10. Specify address to which galley proofs should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.
- 11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.
- 12. It is understood that material is submitted for exclusive publication in Michigan Medicine.

Michigan Medicine

IN THIS ISSUE

SCIENTIFIC ARTICLES

- 1125 The Coronary Care Unit: A Six-Month Experience in a Community Hospital; Lyall K. Moore, M.D.
- 1129 A Project to Assist Community Hospitals in Establishing Coronary Care Units; Ralph E. Lewis, M.P.H.
- 1133 The Fate of the Monkey and the Criminal; Robert D. Visscher, M.D., and Harrison C. Visscher, M.D.
- 1137 Retrocaval Ureter: A Case Report and Successful Repair with a New Surgical Technique; Marcelo R. Peisojovich, M.D., and Sherwin J. Lutz, M.D.

SPECIAL ARTICLES

1151 The Professional Service Corporation in Michigan; A. Stewart Kerr
1179 Muskegon Doctors Release Figures of Study of Their Relationship
with Blue Shield; Leland E. Holly, II, M.D.

GOVERNMENTAL-MEDICAL CARE PROGRAMS, Pages 1187-1189

PHOTO SECTION, pages 1161-1168, inclusive

OTHER FEATURES

- 1115 Breaking News
- 1119 President's Page
- 1123 Officer's Page
- 1142 Monthly Surveillance Report
- 1147 Our State Society 1147 Mediscene
- 1176 Editorial Views
- 1177 County Societies
- 1192 Michigan Authors
- 1147 New Members
- 1201 News Briefs
- 1204 In Memoriam
- 1209 Legal
- 1212 Notes and Quotes

NEXT MONTH

Reports on Michigan's Community Health Week observances, including the text of Governor William Milliken's kick-off speech on his health programs and on the MSMS Second Annual Sex Education Workshop, as well as a complete alphabetized index to all scientific articles appearing in the 1969 issues of MICHIGAN MEDICINE are in the works for the December issue.

ABOUT THE COVER

The photograph on the cover of the attractive scenic setting is the fine work of Tom Barber, young art teacher at Coloma. Tom is a recent graduate of Western Michigan University and already has had some of his photographs chosen for permanent exhibits and for special shows.

MICHIGAN MEDICINE is the official organ of the Michigan State Medical Society, published monthly under the direction of the Publication Committee. Published Semi-Monthly, Trimonthly in November and December; 26 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, \$9.00; single copies, 80 cents. Additional postage: Canada, \$1.00 per year; Pan-American Union, \$2.50 per year; Foreign, \$2.50 per year. Printed in USA. All communications relative to manuscripts, advertising, news, exchanges, etc., should be addressed to Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351. © 1969 Michigan State Medical Society.

That's the nice thing about Blue Shield's Michigan Variable Fee protection. MVF is not only designed to provide broad benefit coverage for your patients, but also to pay most doctor bills in full for covered services.

Of course the chief purpose of MVF is to give the community the best possible protection against the costs

of unexpected medical treatment, to make sure financial considerations never become a barrier to good healthcare. But full payments through Blue Shield MVF also mean that nobody has to worry about most doctor bills for covered services. Not even doctors.

MICHIGAN BLUE SHIELD

Unctors shalldn't have to Worry about doctor hills



MICHIGAN STATE MEDICAL SOCIETY

120 West Saginaw (P.O. Box 152) East Lansing, Mich. 48823 Area Code 517, 337-1351

	CRETARY Brooke		
TREASUR	ERJohn 1	Vluicokon M	D Pontice
ASST TRI	EASURERC. Alle	Dorma M.D.	Cound Danida
CDEAKED	LASURERC. All	n rayne, M.D	D. Grand Rapids
VICE CDE	James	b. bloagett, M.	D Detroit
DACE DDE	AKERVernor	v. Bass, M.D.	Sagınaw
PASI PRE	SIDENT James	J. Lightbody, M.	1.D Detroit
COUNCIL	CHRRoss V	7. Taylor, M.D.	Jackson
VICE-CHA	IRMANRalph	R. Cooper, M.I.	Detroit
COUNCIL			
Sidney Ad	ler, M.D	lst	Detroit
Ralph R. (Cooper, M.D	1st	Detroit
Don W. M	IcLean, M.D	1st	Detroit
Milton R.	Weed, M.D	1st	Grosse Pointe Park
Robert K.	Whiteley, M.D	1st	Detroit
Ross V. Ta	aylor, M.D	2nd	Jackson
Robert M.	Leitch, M.D	3rd	Union City
Don Mars	hall, M.D	4th	Kalamazoo
	dden, M.D		
Ernest P. 6	Griffin, Jr., M.D	6th	Flint
John J. Co	oury, M.D	7th	Port Huron
	ander, M.D		
	McClay, M.D		
Robert C.	Prophater, M.D	.10th	Bay City
Brooker L.	Masters, M.D	.11th	Fremont
	eMire, M.D		
	Franck, Jr., M.D		
Harold F.	Falls, M.D	.14th	Ann Arbor
	her, M.D		
EXECUTI	VE DIRECTORI	Hugh W. Brenne	eman East Lansing
	TE EX. DIR		
	COUNCEL		

GENERAL COUNSEL.....Lester P. Dodd......Detroit

LEGAL COUNSEL..... A. Stewart Kerr..... Detroit

ECON. CONSULTANT..... Clyde T. Hardwick...... Detroit

HISTORIAN..... Wm. J. Stapleton, Jr., M.D. Detroit

ASS'T HISTORIAN...... Wm. M. LeFevre, M.D. Muskegon

PRESIDENT..... Robert J. Mason, M.D.....Birmingham

PRESIDENT-ELECT. . Harold H. Hiscock, M.D. Flint

SECRETARY..... Kenneth H. Johnson, M.D..... Lansing

SCIENTIFIC EDITOR John W. Moses, M.D., Detroit **EXECUTIVE EDITOR** Herbert A. Auer MANAGING EDITOR **Judith Marr** ASSOCIATE SCIENTIFIC EDITORS Frederick J. Cady, Jr., M.D., Surgery Robert M. Daugherty, M.D., Basic Science East Lansing Harold E. De Pree, M.D., Medicine Kalamazoo Dean C. Elliott, M.D., Otolaryngology Petoskey Tommy N. Evans, M.D., Obst.-Gyn. Detroit E. Richard Harrell, M.D., Dermatology Ann Arbor Dorin L. Hinerman, M.D., Pathology Ann Arbor Samuel D. Jacobson, M.D., Medicine Detroit Benjamin Jeffries, M.D., Psychiatry Detroit Raymond S. Kurtzman, M.D., Radiology Detroit A. Martin Lerner, M.D., Medicine Detroit George H. Lowrey, M.D., Pediatrics Ann Arbor Carl A. Moyer, M.D., Surgery Baraga Charles E. Parkinson, M.D., Radiology **Battle Creek** John C. Pierce, M.D., Medicine **Grand Rapids** Frank H. Power, M.D., Surgery Traverse City J. G. Turcotte, M.D., Surgery Ann Arbor Alexander J. Walt, M.D., Surgery Park W. Willis, III, M.D., Medicine Ann Arbor Richard E. Wunsch, M.D., Medicine Traverse City

Publication Committee

Brooker L. Masters, M.D. Harvey C. Hansen, M.D. William A. LeMire, M.D. Don Marshall, M.D. Don W. McLean, M.D. Edward H. Rodda, M.D. Milton R. Weed, M.D.



The Coronary Care Unit: A Six-Month Experience in A Community Hospital

BY L. K. MOORE, M.D. FLINT

The first two coronary care units were opened in 1962 in Kansas City and Philadelphia. At that time Doctors Day, Kitchell and Meltzer observed that nearly fifty percent of the deaths attributed to acute myocardial infarction were due to arrhythmias. This knowledge instigated the development of continuous electracardiagraphic monitoring with a prepared system for terminating ventricular fibrillation and ventricular standstill in an effort to reduce the morality from acute myocardial infarction.

McLaren General Hospital, situated in Flint, Michigan, is a 318-bed hospital with a graduate education program affiliated with the University of Michigan and participates in an active intern and resident program. The coronary care unit which began its operations Sept. 1, 1967, consists of 5 beds in a side room adjacent to the main medical ward. Separate cardiac monitors are available for each patient and electrocardiagraphic recordings may be made directly on paper and displayed on oscilloscopes. These cardiac monitors include bulit-in heart rate meters and automatic external pacemakers. Sample electrocardiographic strips are available automatically on alarm, as well as on demand or selective intervals. Each patient can be easily seen due to the presence of the nursing station within the unit. All nurses receive instructions in the care of patients with acute myocardial infarction, in recognition of arrhythmias, and are trained in resuscitation procedures. Weekly to bi-weekly conferences are held to maintain a high level of competence and enthusiasm.

THE PURPOSE of this study was to compare the progress of patients with acute myocardial infarction over comparable six month periods before and after opening of the coronary care unit. Figure 1 shows that 155 patients were admitted to the coronary care unit over the first six month period, an average of 26 patients per month. The average stay of patients was 5.5 days. Eighty-eight percent of the 155 patients were admitted directly to the unit. Figure 2 shows the admitting diagnosis of the 155 patients.

The majority of patients (57%) were admitted with a provisional diagnosis of acute myocardial

The author was a resident in internal medicine at McLaren General Hospital, Flint, at the time this article was written. He has since taken a new position in Regina, Saskatchewan.

ADMISSIONS TO CORONARY CARE UNIT

September 1, 1967 - February 28, 1968 (6 months)

1.	Patients	155
2.	Average Patients/ Month	26
3.	Average Patient Stay (Days)	5.5

Fig. 1

ADMITTING DIAGNOSIS

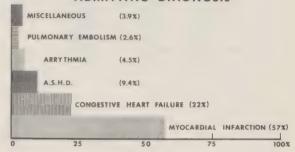
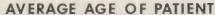


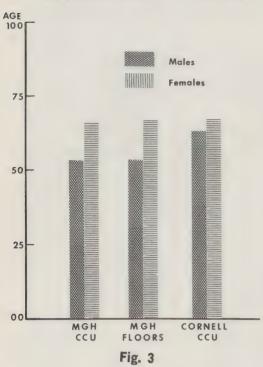
Fig. 2

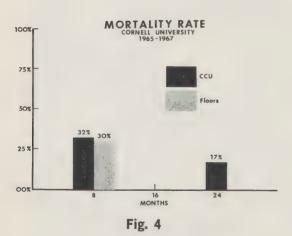
infarction, while the second most common provisional diagnosis was congestive heart failure (22%). Of those patients admitted with a diagnosis of an acute myocardial infarction, 68 percent were proven either by electrocardiography or an autopsy. Of the patients proven to have an acute myocardial infarction, 87 percent were male; that is a ratio of male: females being 6.7:1. Figure 3 shows the average age of the male patient to be



SCIENTIFIC PAPERS







52 years while that of the female to be 68 years. Comparable figures are seen in patients proven to have acute myocardial infarction admitted to other floors of McLaren General Hospital over a sixmonth period prior to the opening of the coronary care unit.

A SIMILAR study carried out at Cornell University (Figure 4) over a two-year period from the opening of their coronary care unit in 1965 to 1967 showed the mortality rate for acute myocardial infarction over an eight-month period to be 32 percent compared with a 30 percent mortality for patients treated for acute myocardial infarction on other medical floors.² After a two-year period, however, the mortality for patients treated in the coronary care unit was significantly

MORTALITY RATE

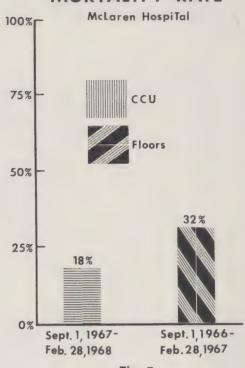
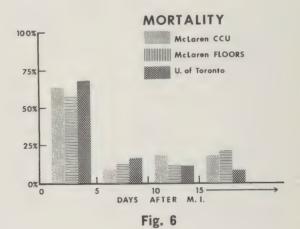


Fig. 5



improved and was found to be seventeen percent. Reference to Figure 5 shows that the mortality rate for acute myocardial infarction in patients managed on various medical floors at McLaren General Hospital over a six-month period from September, 1966, through February, 1967 was 32 percent. During the first six-month period of operation of the coronary care unit from September, 1967, through February, 1968, the mortality

rate had significantly decreased to 18 percent.

Figure 6 shows a comparison study and indicates the time of death after acute myocardial infarction. As can be seen, the majority of deaths occurred during the first five days post-myocardial infarction. Reference to the study done at the University of Toronto shows the more typical

progressive reduction in mortality over the succeeding days post-myocardial infarction.

In this study it was found that the most common cause of death was due to arrhythmias (55%), the remaining causes due to congestive heart failure and/or shock (45%). Ventricular fibrillation was the most common arrhythmia (63%) leading to death, and in almost all of these cases, premature ventricular contraction preceded this grave arrhythmia.

In general, it is felt that the patient should be confined to the coronary care unit for an average of 5 days.³ The most serious complication and highest mortality occurs during the first few days and especially the first 24 hours after an acute myocardial infarction.^{4,6,7} It has been suggested that 33 to 50 percent of the mortality occurs during the first 24 hours, 70 percent during the first three days and 80 to 85 percent during the first week.⁵

ARRHYTHMIAS ARE the most common cause of death and ventricular fibrillation occurs most commonly during the first 72 hours.5 Friedberg has indicated that if hypotension occurs, 62 percent will develop it within the first 24 hours and 91 percent in the first 72 hours.3 Comparable statements have been made in which 70 percent of the deaths were found to occur during the first five days after acute myocardial infarction.1 This reflects the importance of admitting patients early to a coronary care unit when suspected of an acute myocardial infarction. The greatest salvage of life is going to be during the first few hours, the first few days post-myocardial infarction. Hopefully, various arrhythmias and hypotension can be prevented or at least detected during the first few hours and treatment instituted early with control of these complications in approximately 5 days.

Congestive heart failure, if it develops, usually becomes clinically manifested in one to three days and usually can be controlled in a five to seven day period. Pulmonary embolism, if it occurs, usually does so during the first or second week; however, it may occur during the first few days postmyocardial infarction.³ Anti-coagulation and other measures to prevent phlebothrombosis and resultant pulmonary embolism are instituted on admission of the patient to the coronary care unit.

Hopefully, all patients suspected of an acute myocardial infarction would be admitted to the coronary care unit. During this study patients were not selected for admission on the basis of severity of illness but were admitted directly to the coronary care unit on the basis of bed availability. Only after beds became available could patients be transferred to the unit for continued intensive care. It is also expected that a few patients will be suspected of an acute myocardial in-

farction only after a few hours or days of hospitalization and at that time require admission to the coronary care unit.

THESE REASONS are thought to partly explain the 12 percent of the patients who were not admitted directly to the unit. Again, it is stressed that patients suspected of having an acute myocardial infarction be admitted directly to the coronary care unit for as it can be seen from our study only 68 percent of the patients admitted with a provisional diagnosis of acute myocardial infarction actually proved to have an acute myocardial infarction. This suggests that patients were admitted promptly and without selection. In this study 57 percent of the patients admitted to the unit had a provisional diagnosis of acute myocardial infarction and 22 percent a provisional diagnosis of congestive heart failure. It is thought that the majority of patients admitted with the diagnosis of congestive heart failure were also suspected of an acute myocardial infarction which had either precipitated or aggravated heart failure. Therefore, perhaps more nearly 79 percent of the patients admitted to the unit were suspected of an acute myocardial infarction. The coronary care unit should be reserved for these patients, and patients with other diagnoses if requiring intensive care, should be admitted to other intensive care facilities.

As is well known, the incidence of arteriosclerotic heart disease and myocardial infarction in the female is much less than the male up to the age of the menopause. Friedberg mentions a ratio which varies from series to series of 2 male:1 female to 6 male:1 female.³ It is also known that this ratio diminishes after age 65 years and that the average age of females of myocardial infarction is higher than males.³ In a study undertaken by W. H. Longhorne, a mean age for males of 57 years and for females of 66 years was found.⁷ These figures are similar to the ages we found in this study.

As can be noted from the study undertaken at Cornell University there was no statistically significant improvement in the mortality rate for the patients treated in the coronary care unit during the first eight months as compared with those treated on the medical floors. After a two-year period, however, the mortality rate for patients treated in the coronary care unit was significantly improved and was found to be 17 percent. Studies have shown the mortality rate for acute myocardial infarction of hospitalized patients prior to institution of the coronary care units was approximately 33 percent.1 The overall mortality is higher, as many patients with acute myocardial infarction die prior to hospitalization⁵ and therefore, the overall mortality may be thought to approach approximately 43 to 53 percent. Experience has shown that the mortality rate for patients treated in the coronary care unit during the first approximate six months of its institution is not reduced to any statistically significant extent.1 The reasons are thought to be due to the relative inexperience of the paramedical and medical staff. There must be a constant and intensive program of training for all personnel. The nurses must be trained in the care of these patients, and in particular to recognize minor arrhythmias in order that they may notify the physician so that proper therapeutic measures may be instituted in an effort to prevent major complications. After the coronary care unit has been in operation for approximately one year there should be a significant decrease in the mortality rate with most centers reporting a mortality of approximately twenty to twenty-five percent. 1 By the end of the second year it is thought that the maximum decrease in mortality should be achieved and is approximately 10 to 15 percent. One study shows a reduction in mortality over an 18-month period from 34 percent (regular hospital admissions) to 19.7 percent for patients treated in the coronary care unit.8 In our study an encouraging reduction in mortality is seen from 32 percent for patients with acute myocardial infarction treated on various medical floors to 18 percent for those patients treated in the coronary care unit during the first six months of its operation. It is true that this study is over a relatively short period of time; however, as can be understood, we are greatly encouraged by this favorable reduction in mortality and hope to see a continued low and even lower mortality over succeeding months. At this hospital there is a continuing intensive program of education of all medical personnel in regards to care of the patient with acute myocardial infarction.

It has been shown that the factor in reduction of this mortality is the prevention of life-threatening arrhythmias. It is concluded that the prompt admission to a coronary care unit of all patients suspected of an acute myocardial infarction and the early recognition and treatment of "minor" arrhythmias in an effort to prevent "major" arrhythmias, is the hope for reduction in mortality for patients with myocardial infarction.

I wish to thank H. Sparks, M.D., and L. Reynolds, M.D., for help in this project.

REFERENCES

- A Symposium presented by the American College of Cardiology and Presbyterian University of Penn. Medical Center, Philadelphia, Penn., 1966.
- Killip, T., and Kimball, J. T.: Treatment of Myocardial Infarction in a Coronary Care Unit. The American Journal of Cardiology, Vol. 20, October, 1967.
- 3. Friedberg, C. K.: Diseases of the Heart. Saunder's Edition III, 1966.
- Fields, J.: Cardiac Resuscitation in Coronary Artery Disease. A Central Coronary Care Unit. J.A.-M.A. 184:453, 1963.
- Mower, M. M., Miller, D. I., and Nachlas, M.M.: Clinical features relevant to possible resuscitation in death after acute myocardial infarction. American Heart Journal, 67:437, 1964.
- Bainton, C. R., and Peterson, D. R.: Deaths from Coronary Heart Disease in Persons Fifty Years of Age and Younger. N.E.J.M., 268:569-574, 1963.
- 7. Longhorne, W. H.: The Coronary Care Unit. J.A.M.A., Vol. 201, No. 9, 1967.
- 8. Church, G.: Small Hospital Finds Coronary Care Unit Practical. J.A.M.A., Vol. 203, No. 4, 1968.
- MacMillan, R. L., Brown, K. W. C., Peckham, G. B., Kahn, O., Hutchinson, D. B., and Paton, M. Changing Perspectives in Coronary Care. The American Journal of Cardiology. Vol 20, October, 1967.
- Lown, B., Shillingford, J. P.: Symposium on Coronary Care Units. The American Journal of Cardiology, Vol. 20, October, 1967.

A Project To Assist Community Hospitals In Establishing Coronary Care Units

BY RALPH E. LEWIS, M.P.H. ANN ARBOR

ABSTRACT

This cooperative effort between the University of Michigan and the Michigan Heart Association is designed to assist and encourage community hospitals in Michigan in establishing coronary care units. Physician, nursing, engineering, and architectural consultation will be provided; matching monies may be applied for to permit construction or renovation of space, and equipping of new coronary care units after staffs are trained.

The participants anticipate working with a minimum of 36 hospitals, and hope to establish at least 144 new coronary care beds over the 3 year life of the project.

The project is supported by the W. K. Kellogg Foundation of Battle Creek.

INTRODUCTION

In the past two decades there have been important advances in the care of patients with cardiovascular disease. Most notable has been the operative treatment of valvular disease and congenital heart defects with important reductions in mortality and the return of many such patients to a useful productive life. Yet the mortality from coronary artery disease has remained unaffected. Year after year myocardial infarction or the "heart attack" and its complications exacts the highest toll of any single disease. In large metropolitan hospitals, the death rate of patients hospitalized for this condition ranges from 30 to 40%. Certain facts are forcing a re-evaluation of this problem.

Sudden death in myocardial infarction is not necessarily related to the extent of the infarct or damaged heart muscle, but is usually due to serious disturbances of heart rhythm which usually appear early and tend to disappear in a few days. Thus, if these potential causes of early death are successfully prevented or treated, cardiac function may be kept at a satisfactory level.

PEAK MORTALITY occurs at the very onset

Mr. Lewis is project coordinator of the project which he describes, and program associate, Department of Postgraduate Medicine, The University of Michigan Medical Center.

of myocardial infarction and then recedes almost exponentially with 65% of deaths occurring in the initial three days and 85% during the first week after the attack. Arrhythmias account for at least 40% of deaths. Of these about two-thirds are caused by ventricular fibrillation and one-third are caused by conditions associated with a slow heart rate, heart block and asytole. It is well established that these electrical accidents are usually not due to irreversible cardiac damage. On the contrary, experience indicates that prompt treatment can often restore integrated cardiac activity and permit full recovery.

These considerations have led to the design of specialized hospital areas, coronary care units, where the patient with a recent heart attack can receive prompt and effective treatment. Where such units are operating, there has been a reduction in mortality from the 30 to 40% achieved with standard hospital care, to 11 to 20% reported by several coronary care units. These figures are so constant that there is no longer any doubt of the value of coronary care units. The problem now concerns applying the techniques and information learned in large medical centers to the community hospital.

From the Second Bethesda Conference of the American College of Cardiology the following statement summarized the role of the coronary care units: "It is in the area of cardiac resuscitation and management of arrhythmias that modern medical development permits the maximum impact on mortality, provided prompt recognition and aggressive treatment are skillfully applied." Implied in this statement is the need for trained staff, and this emphasizes the need for training programs on a state level as well as smaller seminars held at weekly intervals by the coronary care unit staff itself.

FOLLOWING SUCCESSFUL experience with a small community hospital coronary care unit in Standish, Michigan, the W. K. Kellogg Foundation has made a three year grant to the University of Michigan in cooperation with Michigan Heart Association to help in developing coronary care units in community hospitals.

By establishing training programs for physicians, nurses, and related health personnel, by develop-

GENERAL HOSPITAL SIZE	NO. OF HOSPITALS	EXISTING CCU OR COMB. UNITS
Over 200 acute beds	60	46
100 - 200 acute beds	64	21
50 - 100 acute beds	58	8
1 - 50 acute beds	72	4
Total Hospitals	254	
Total Hospitals		
with CCU-ICU		79 (384 beds)
Total Hospitals		neus)
Total Hospitals without CCU	470	
Without CCO	175	

Fig. 1. — Number of hospitals with CCU-ICU's by hospital bed size (source: Michigan Heart Association, 1968)

ing guidelines for evaluation of the effectiveness and utilization of coronary care units, and through matching monies for renovation and/or construction and purchase of equipment, the project participants see a reduction in the mortality of hospitalized victims of heart disease involving the coronary arteries as the expected direct result of the project.

CURRENT STATUS OF CCU'S IN MICHIGAN

At present in Michigan there are 43 Coronary Care Units and 36 Intensive Care Units with coronary care beds (Figure 1). This provides 384 monitored beds located in the state in 79 CCU's and ICU-CCU's of Michigan's 83 counties. It is estimated that there is need for at least an additional 360 beds in new CCU's (Figure 2).

There are 182 general hospitals staffed by M.D.'s and D.O.'s having 50 or more acute beds in Michigan. There are 72 hospitals with 50 or less beds. Ninety-three hospitals in the 50 to 200 bed class and 68 hospitals having 50 beds or less do not provide coronary care service.

PROJECT OBJECTIVES

The objective of this project is to achieve a reduction in mortality among Michigan residents hospitalized for heart disease involving the coronary arteries, by developing the necessary hospital, medical and nursing capability within reasonable distance of all Michigan citizens.

The knowledge for achieving this objective is available, but making the resources and skills accessible to the total population of Michigan requires new financing, organization and direction.

Basically, the means for accomplishing the project objective is to guide and stimulate the development of specially designed, equipped and staffed hospital coronary care units in which pa-

CCU BEDS PER HOSPITAL	TOTAL NUMBER OF NEEDED BEDS
Over 200 acute beds	
5+ beds x 60 hospitals	300+
100 - 200 acute beds 4 beds x 64 hospitals	250
50 - 100 acute beds	256
2 beds x 58 hospitals	116
1 - 50 acute beds 1 bed x 72 hospitals	72
Total required CCU beds	744
Reported CCU beds	384
Estimate of needed CCU beds	360

Fig. 2. — Estimated number of needed coronary care unit beds by hospital size (source: Michigan Heart Association, 1968)

tients may receive constant electronic monitoring and intensive observation and treatment.

PROCEDURES

It is anticipated that the project will utilize a four-phase program in each of four regions in the state. These would be: (1) hospital selection and planning, (2) physician and nurse training, (3) coronary care unit design and construction, and (4) follow-up training assistance and evaluation.

The four regions are: The upper peninsula, the southeastern and southwestern divisions of the lower peninsula, and the northern section of the lower peninsula, above Bay City.

Over-all guidance of the program is accomplished through a Policy Advisory Committee, composed of physicians, hospital administrators, nurses, and key community leaders. It will determine policy as developed by the staff, and is responsible for selection of hospitals, resolution of conflicts and arbitration of disputes; it will provide continuous monitoring of the project's progress and will restructure the project if necessary.

A small working group of project staff will make the day to day operational decisions for the project, and will have as their primary responsibility that of preparing and implementing policy.

A Regional Steering Committee will be composed of representatives of the project staff, policy advisory committee and others drawn from the hospital staffs of the four regions involved. Thus, decisions affecting each region will be made at the local level.

ROLES OF PARTICIPANTS

The Michigan Heart Association (MHA), a voluntary non-profit health agency, has maintained an

interest in coronary care since 1964, when the association's coronary care unit (CCU) committee was formed.

In 1964, MHA was host to a national regional conference on resuscitation and coronary care, and in 1966, MHA sponsored workshops on coronary care in Lansing, Grand Rapids, Flint and Marquette.

To meet the growing need for trained nurses, MHA, through its Professional Nurse Committee, developed its first two-week CCU training program in 1966. Since that time, additional courses have been held around the state.

It was apparent that if MHA was to increase its efforts in coronary care, outside resources had to be obtained. A project for physician and nurse training was developed and submitted to the Michigan Association for Regional Medical Programs, and funded in 1968.

The Michigan Heart Association will provide a major portion of the physician and nurse education for the hospitals selected for participation in the Kellogg project. The program will offer basic instruction to physicians and nurses and will form the foundation of technical skills required for the coronary care concept.

Members of the MHA staff will provide the necessary consultation and coordination of the training program; the agency's extensive film library, teaching library of tapes and slides, together with an arrhythmia trainer, are available on loan to community hospitals and a reference library of coronary care unit education materials will be available for loan.

The University of Michigan's Department of Post-graduate Medicine with extensive experience with community hospitals during its 41 years of existence, will provide overall administrative and fiscal coordination of the project, and will assist in mobilizing other University resources. It will coordinate on-going consultation with hospitals after the CCU is open and has had experience with patients. In cooperation with other project participants, the Department will co-sponsor educational programs designed to acquaint hospital administrators and boards of trustees with the essential medical and physical aspects of the hospital care of the acute coronary heart disease patients.

The Department of Postgraduate Medicine will also provide services directed toward planning the placement of CCU's, forecasting bed and staffing needs, suggesting patterns of medical and administrative organization, consulting on operating policy and providing assistance to hospitals on CCU design and construction. A primary role will be to identify pockets of unmet need, define some individual hospital service areas, and to correlate un-

met need with hospitals most appropriate for providing needed services.

The placement of coronary care units will not be a simple process and will require a consideration of individual hospital capability as well as the needs of the population served.

A set of hospital policies will be developed to govern the operation of each CCU. It seems reasonable to share with project hospitals the experience at other ongoing units. Policies must include financing, staffing, medical and nursing administrative management, and medical-legal problems.

A good deal of information is available on the design of physical facilities, electrical specifications, monitoring equipment, size of patient rooms, location of the unit, and other detailed architectural and engineering questions. Assistance will be sought from architectural consultants with experience in this field. Using local architects as consultants on the extremely technical task of designing a coronary care unit is usually not the best solution. One of the strengths of this project is the expertise in coronary care unit design readily available to the small hospital.

The Heart Station, Division of Cardiology, University of Michigan Medical Center, will investigate with existing coronary care units in Michigan hospitals current procedures, techniques and concepts of coronary care to determine effectiveness, reliability and validity. It will investigate, through research and development, new ideas, concepts, procedures and equipment.

The Heart Station will provide physician personnel to teach and consult in community hospitals, and will have primary responsibility for evaluation aspects of the coronary care unit project.

The research and development phase is an effort to provide improved monitoring instrumentation through research directed toward patient needs. Two projects are proposed for the first year. A few cooperating hospitals will be equipped to transmit on-line data from patient monitors via telephone lines for processing by statistical methods with specially designed computers located at Ann Arbor. Specifically the electracardiographic signal received from remote hospitals will be converted into an R-R interval histogram to provide a permanent taped record of events. This will provide a day-to-day evaluation of therapy in the unit, record of the arrhythmias occurring in the patient and an evaluation of individual therapeutic agents. Immediate results can be made available by telephone and permanent records forwarded later.

The second project is the design and construction of a storage oscilloscope with a raster display of six lines of EKG rather than the conventional single line. Since in a storage display, the EKG does not fade from the screen, the recognition of arrhythmias is much easier. In the event of an alarm, the erase circuit is inactivated "storing" the arrhythmia on the screen. In normal operation the screen will erase at the completion of the sixth line of EKG. If, after testing, the instrument proves feasible, it will be made available for local implementation. If desired the entire circuit can be built by local engineers and furnished at cost plus fee to cover construction time.

The University of Michigan School of Nursing, through a postgraduate nursing grant from regional medical programs, will provide advanced CCU training for nurses to supplement other training; in addition, nurse consultation in unit management, motivational techniques, inservice education, and nursing policies will be provided.

EVALUATION

Evaluation in an undertaking of this type is important, but to burden hospitals with unrealistic or overwhelming evaluation requirements would jeopardize the success of the project at the onset. Evaluation methods will be determined by the staff and the policy advisory committee, and might consist of:

- 1. Use of a discriminate analysis or other rating form to allow hospitals to compare their efforts in coronary care against that of other hospitals.
- 2. Collecting a certain uniform (and minimal) amount of data, for analysis and reporting to the project advisory committee. Individual hospitals would of course be free to collect as much other data as they wish.
- 3. Measuring the effectiveness within the hospital of physician and nurse continuing education programs in coronary care.

SUMMARY

This effort may be unique in that it brings together the efforts of a state university, a voluntary health agency, the federally funded regional medical programs, and private funds from the W. K. Kellogg Foundation to cooperatively attack a major health problem in Michigan.

By encouraging and assisting community hospitals in establishing new coronary care units, and training physicians and nurses in the coronary care concept, a reduction in mortality from heart disease in hospitalized patients in Michigan is expected as a direct result.

The Fate of the Monkey and the Criminal

BY ROBERT D. VISSCHER, M.D. HARRISON C. VISSCHER, M.D. GRAND RAPIDS

INTRODUCTION

In 1940, Landsteiner and Wiener announced the discovery of the Rhesus antigen, so-called because it was originally found on the red cells of the Rhesus monkey. One year previous, Levine and Stetson, described an atypical agglutinin (anti-Rh antibody) in the blood stream of a woman who had given birth to a stillborn. These discoveries helped define the pathogenesis of hemolytic disease of the newborn which at that time clinically manifested itself as hydrops, icterus gravis and anemia, and had a perinatal mortality of 50%.

Through the advent of exchange transfusions, serological studies, pre-term deliveries, amniocentesis and intrauterine transfusions, this perinatal mortality has been lowered to approximately 10%.

However, with the knowledge that the inital immune response usually occurred following fetal-maternal hemorrhages during labor and delivery, it was hoped that it would be possible to discover a way to prevent Rh isoimmunization from occurring altogether. With the development of Rh immune globulin (passive anti-Rh antibody) and its demonstrated ability to prevent sensitization of Rh-negative mothers after the delivery of an Rh-positive infant, we now have the means of radically reducing the incidence of this disease and its associated perinatal mortality.

We would like to present the statistics of our Grand Rapids study which took place in three community hospitals as an example of one of the field trials that proved the efficacy of this product.

STUDY AND RESULTS

All non-sensitized Rh-negative women who delivered from May 1, 1967 to May 20, 1968, in our three hospitals were interviewed. Serological studies were performed on the mothers' blood and infants' cord blood to confirm that she was a nonsensitized, Rh-negative, Du-negative patient with

This study was conducted at Blodgett Memorial Hospital, Butterworth Hospital and St. Mary's Hospital in Grand Rapids. It was supported by a grant from the John A. Hartford Foundation, Inc., New York City, through the Blodgett Memorial Hospital Research Department.

TABLE I PREVENTION OF Rh ISOIMMUNIZATION

Grand Rapids Study — Part I I May 1967 - 16 Nov. 1967

Patients interviewed		224
Patients not injected		76
ABO incompatible baby	34	
Positive antibody screen	9	
Crossmatch incompatibility	5	
No Rh immune globulin	14	
Patients refused	14	
Patients injected		148
6-month follow-up		142
Sensitized	0	
Not sensitized	142	
Subsequent Rh-positive pregnancies		24
Sensitized	0	
Not sensitized	24	

an ABO compatible Rh-positive infant. Those who were, and consented to be a part of the study, were injected. The project was divided into two parts.

In the first part (Table 1.) 148 mothers received Rh immune globulin,* 300 ug. IM within 72 hours of delivery. One hundred forty-two were followed for six months or more and none have become sensitized. Twenty-four subsequent Rhpositive pregnancies likewise have shown no evidence of hemolytic disease of the newborn. The second part of the study (Table 2.) was a doubleblind control study in 138 patients. Of the 75 control patients who received plain y-G globulin IM. 71 patients have been followed for more than six months and two have become sensitized for a rate of 3%. Fifty-nine of the 63 patients treated with Rh immune globulin 300 ug IM have been followed for more than six months and none have shown any evidence of sensitization. Seven Rhpositive pregnancies in this part have shown no evidence of hemolytic disease either. These results show that Rh immune globulin given within 72 hours of delivery is very effective in preventing Rh isoimmunization.

DISCUSSION

The immunological principle that passive antibody in the presence of its corresponding antigen prevents immunization is not a new theory (Smith, J. Exp. Med. 11:241, 1909). However, this theory had not been proven as far as the Rh sys-

^{*}RhoGAM supplied by Ortho Research Foundation, Raritan, New Jersey

TABLE II PREVENTION OF Rh ISOIMMUNIZATION

Grand Rapids Study — Part II 17 Nov. 1967 - 20 May 1968

		181
		43
	16	
	1	
	3	
	12	
	11	
		138
	75	
	63	
		130
	71	
2		
69		
	59	
0		
59		
	69	1 3 12 11 75 63 71 2 69 59

tem was concerned. It remained for the New York study (Freda et al. Fed. Proc. 22: 374, 1963) and the British study (Finn et al, Brit. Med. J. 1:1486, 1961) in Rh-negative male volunteers to establish the fact that this theory does apply to the Rh system.

The mode of action of Rh immune globulin in preventing Rh isoimmunization is not specifically known. It does not depend on intravascular lysis of the erythrocytes and sequestration in the liver. Present evidence indicates that the passively administered anti-Rh antibody competes with the immunologically competent cells in the lymph node and spleen for antigen or RNA-antigen complex, or prevents processing of antigen by macrophages (Pollack et al, *Transfusion* 8:134, 1968). This effectively blocks the stimulus for formation of germinal centers of antibody producing clones of plasma cells.

The quantity of Rh immune globulin necessary to suppress the immune response does seem to be related to the size of the antigenic stimulus—i.e., the size of the fetal-maternal bleed. The quality of the antibody (binding capacity) is also a factor. Although the exact quantity of Rh-positive cells

that 300 ug. of Rh immune globulin with a binding constant of 108 will protect against is not known, clinical trials have demonstrated that this dose covers more than 99% of the fetal-maternal hemorrhages that occur at the time of labor and delivery (Pollack et al, *Transfusion* 8:151, 1968).

THE HALF-LIFE of the injected immune globulin depends on whether it is bound or free. Antibody that is bound to Rh-positive cells may or may not be rapidly cleared from the circulation by the spleen. Its half-life is similar to that of the red cells involved. Free immune globulin in the serum behaves- as any γ -G globulin and has a half-life of approximately 25 days. As this passive antibody does not remain for long in the blood stream, it is necessary to give an injection of this material after every Rh-positive pregnancy.

After an Rh-negative woman has become sensitized, it is absolutely of no value to add to her circulating anti-Rh antibody by giving her an injection of Rh immune globulin. Once the germinal centers for antibody production have been formed, injecting additional anti-Rh antibody will not prevent them from responding to a second antigenic stimulus, or modify hemolytic disease in subsequent Rh-positive pregnancies. Rh immune globulin can only prevent the primary immune response; it will not suppress the secondary immune response.

Rh immune globulin is a biologic product and has been evaluated by NIH. They determined it to be effective and safe when 300 ug. are given IM within 72 hours of delivery. Sterility and purity of the product has not been a problem with the present manufacturing process. The hepatitis virus does not exist in the y-G globulin fraction of serum proteins. Renal disease has not occurred, probably because we are using intramuscular injections and this is not a hemolytic antibody. There has been some concern over the possible enhancement of the immune response, but this has not been a problem with the present dose. As with other y-G globulin preparations that have been used extensively before, our clinical experience to date with Rh immune globulin has not turned up any significant side effects.

OUR STUDY, along with other field trials (Pollack et al, Transfusion 8:151, 1968), has shown that Rh immune globulin given within 72 hours of delivery is more than 99% effective in preventing Rh isoimmunization after Rh-positive pregnancies. Even though the incidence of sensitization is decreased with ABO incompatible pregnancies and with passive management of the third stage of labor, fetal-maternal hemorrhages and subsequent isoimmunization cannot be prevented entirely. So it is recommended that all non-sensitized Rh-negative Du-negative mothers who deliver an Rh-positive infant, regardless of ABO

blood groups, be given Rh immune globulin 300 ug. IM within 72 hours of the delivery. Following is a sample plan for the management of the nonsensitized Rh-negative patient which focuses on the prevention of Rh isoimmunization by proper management of labor and delivery and giving Rh immune globulin to eligible patients. If all obstetricians would incorporate this plan into their management of these patients, it would have a tremendous effect on the fate of the anti-Rh antibodies which criminally assault the Rhesus antigen on the fetal cells.

THE MANAGEMENT OF THE NON-SENSITIZED Rh NEGATIVE PATIENT

Antepartum

- I. All maternity patients should have an Rh determination as part of their initial laboratory studies.
- II. All Rh negative patients should have an antibody screen for atypical antibodies in the first trimester.
- III. If the antibody screen is negative, it should be repeated at 26-28 weeks and 32-34 weeks.
- IV. If the antibody screen is positive, the antibody should be identified and titered.
- V. Patients with anti-Rh antibody should be evaluated with serial amniocentesis as outlined in Maternal Health Desk Reference Card No. 9.

Intrapartum

- I. Prevention of large Fetal-Maternal Transplacental Hemorrhages.
 - A. Passive management of the third stage of labor:
 - 1. Do not give oxytocin prior to delivery of placenta.
 - 2. Clamp the cord immediately after delivery, incise it, and then, allow the maternal end to bleed freely after collecting the cord blood specimen.
 - 3. Assist delivery of the placenta only after it has separated and descended into the lower uterine segment.
 - 4. Give oxytocin IM after the placenta has been completely removed.
 - B. Manual removal of the placenta should only be done if indicated by excessive bleeding or retention greater than 15 minutes.
- II. Prevention of Rh Isoimmunization
 - A. Blood studies to determine eligibility for Rh Immune Globulin. These laboratory studies should be done *Routinely* on *All* Rh negative women and their newborn infants.

- 1. Maternal blood
 - a. Confirm ABO group
 - b. Confirm Rh type
 - c. Antibody screen
- 2. Cord blood
 - a. ABO group
 - b. Rh type
 - c. Direct Coombs
- B. Eligibility
 - 1. Term deliveries. If the above studies confirm that the mother is Rh-negative Du-negative and not sensitized, and the infant is Rh positive with a negative Coombs, the nurse or laboratory technician should notify the attending physician that his patient is eligible to receive Rh immune globulin. Unless the mother is very certain that this is her last pregnancy, all eligible women should routinely receive Rh immune globulin within 72 hours of delivery.
 - 2. Premature deliveries. They should be handled the same as term deliveries. Fetal-maternal hemorrhages are a very definite possibility especially with placental accidents and operative deliveries which are common in this group of patients.
 - 3. Abortions. Although it is theoretically possible to become sensitized after an abortion, there is not specific proof that this occurs. So, it is not necessary to give Rh immune globulin to Rh negative mothers after spontaneous abortions. There is some evidence that fetal-maternal hemorrhages may occur after therapeutic abortions. So, if the father is Rh positive, the mother should receive Rh immune globulin within 72 hours of termination of the pregnancy.
 - 4. During pregnancy. It is very rare to have a large enough fetal-maternal hemorrhage to break through the immune barrier and cause a primary immune response. So it is not necessary to give Rh immune globulin to pregnant women.
- C. Dose
 - 1. The usual dose of human Rh immune globulin (RhoGAM) is 300 ug IM given within 72 hours of delivery.
 - 2. On occasion, the dose should be increased to 600-900 ug if there is clinical evidence of a large fetal-maternal hemorrhage (anemic newborn, unexplained stillborn, severe childbirth chills, manual removal of placenta, etc.); and this is substantiated by laboratory studies such as mixed field

agglutination on the crossmatch, Ashby differential agglutination test, Kleihauer test, etc.

- D. Follow up
 - 1. No specific follow up laboratory studies are necessary between pregnancies.

FUTURE PREGNANCIES

- I. Every future pregnancy that the Rh negative mother has should be followed in the very same way.
- II. The Rh negative mother, assuming she does not become sensitized, should receive Rh im-

mune globulin after each Rh positive pregnancy.

SUMMARY

Results of our Grand Rapids study are presented as an example of one of the field trials that prove the efficacy of Rh immune globulin in preventing Rh isoimmunization. A discussion of immunological principles and practical considerations follows. A sample plan is presented for the management of the non-sensitized Rh-negative patient.

Retrocaval Ureter:

A Case Report and Successful Repair With A New Surgical Technique

BY MARCELO R. PEISOJOVICH, M.D., F.A.C.S. SHERWIN J. LUTZ, M.D., F.A.C.S. DETROIT

INTRODUCTION

An embryological anomaly in the development of the venous system creates an uncommon relationship of the ureter to the vena cava. The relationship is described as retrocaval, postcaval and circumcaval ureter. The condition was first described by Hochstetter in 1893 and until 1946 only 34 cases were reported in medical literature. Of these cases 22 were found at autopsy, 11 were found at operation and one case was diagnosed prior to surgery. (Lowsley, 1946)

Advances in diagnostic methods (urological and radiological) and awareness of the anomalous feature of this condition has made the diagnosis more common and today over 200 cases are reported in medical literature.

The main purpose of this presentation is to report the first case of retrocaval ureter diagnosed at our institution and its successful repair using a surgical technique not reported before.

EMBRYOLOGY

The condition is due basically to maldevelopment of the inferior vena cava in which the right subcardinal vein instead of the right supracardinal vein forms the main portion of the vena cava. The ureter then lies behind and medial to the inferior vena cava instead of remaining laterally, (Hollinhead). A case of left retrocaval ureter in a patient with situs inversus and a few cases of bilateral anomalies have been described.

DIAGNOSIS

This anomaly can be present a lifetime without awareness. When compression of the ureter and compromise of the lumen exist, however, symptoms of obstruction may appear such as flank pain, nausea, vomiting, dysuria or fever.

PHYSICAL EXAMINATION

Examination of the patient will reveal little except for tenderness in the flank on the affected

The authors were with the Department of Urology, Division of Surgery, The Grace Hospital, Detroit, at the time this article was written. Dr. Peisojovich has since taken a new position in Buenos Aires, Argentina.

side. Laboratory studies will show little except for a possible pyuria or microhematuria. A blood count may reveal evidence of a leukocytosis secondary to the infection that may be present.

It is radiologically that the diagnosis will be made. The findings on excretory urography are characteristic and are as follows: 1) Most common is the displacement of the ureter medially toward the spine at L3 or L4. 2) Frequently hydronephrosis and hydroureter of the upper third with the involved area becoming redundant, adopting a characteristic italic S shape are found. 3) On oblique films the ureter is seen hugging the lumbar spine instead of pulling away from it. If the kidney has suffered severe damage the excretory urogram will fail to show details. At this point retrograde studies alone, or combined with a vena cavogram, are valuable and demonstrative.

CASE HISTORY

H.O.G., a 47 year old, while male, with a fourday history of increasing pain in the right flank associated with dysuria and burning on urination was admitted to The Grace Hospital with a diagnosis of right ureteral obstruction. He gave a history of having had nausea and one episode of vomiting but denied fever or hematuria. Physical examination was negative except for mild right flank tenderness. Laboratory studies were within normal limits. An intravenous pyelogram was obtained on admission which revealed a marked right hydronephrosis and dilatation of the proximal third of the right ureter. This ureter was observed coursing laterally to the spine proximally, bent acutely superior and medially at L4 to descend distally superimposing the right lateral aspect of the lumbar vertebral bodies. A presumptive diagnosis of a retrocaval ureter was made. Retrograde studies and drip infusion pyelogram combined with vena cavogram were performed which proved the diagnosis, (Fig. 1).

On the fourth hospital day the patient was operated. At surgery the right ureter was exposed through an oblique incision in the right lower quadrant of the abdomen, extended up to the tip of the 12th rib. It was found to be markedly dilated on its proximal third which coursed laterally to the vena cava. It was noted that at the level of L4, this ureter suddenly became narrow, bent acutely toward the spine and disappeared behind the vena cava for approximately five to six centi-

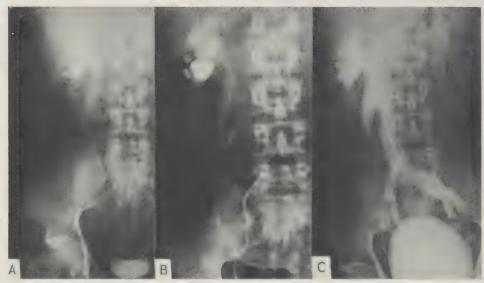


Fig. 1. A. Intravenous pyelogram. B. Retrograde pyelogram. C. Drip infusion pyelogram combined with venacavogram. Characteristic features of a right retrocaval ureter are present.

meters, to reappear over the iliac vessels toward the bladder, (Fig. 2).

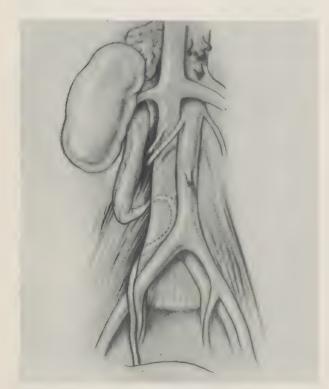


Fig. 2. Schematic representation of anatomical findings at surgery.

Using both sharp and blunt dissection, the ureter which passed behind the vena cava was freed and brought out into the incision. It was noted that there was stricture of this portion which had been compressed behind the vena cava. This area was resected, which left a proximal ureter of adequate lumen but a distal one of reduced caliber. At this point, we thought that by eliminating all strictured ureter, there would not be enough length left to permit an end-to-end anastomosis. Consequently, the distal ureter was split for a distance of about 31/2 centimeters. Adequate ureteral lumen was reached and a posterior five milimeter flap was constructed. This flap was anastomosed end-to-end to the proximal ureter using two interrupted stitches of 4 zero chromic catgut, (Fig. 3). This left an anterior and lateral defect of approximately three centimeters which was void of any ureter. Through a proximal ureterostomy, a #8 T-tube was placed into the ureter as a splint up toward the renal pelvis and down through the defect toward the bladder, (Fig. 4 and 5).

A hemovac drain was placed down to the area of repair. The wound was then closed in layers with the T-tube coming out through a stab wound incision in the anterior abdominal wall. The post-operative course was uneventful. He was on oral feedings 24 hours after surgery and intravenous fluids were discontinued 48 hours after surgery. He was allowed oral antibiotics along with his

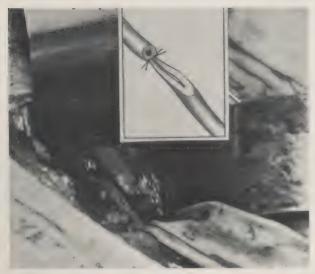


Fig. 3. Posterior ureteral flap and end-to-end anastomosis.

oral feedings. The T-tube was kept clamped from the day of surgery and the urinary output was satisfactory at all times. The patient remained afebrile until his discharge. An intravenous pyelogram was done on the tenth post-operative day which showed some delay in function on the right side and a small extravasation at the operative area. Hemovac suction was removed on the 14th post-operative day after 48 hours without any drainage. Repeated urine cultures were negative and the patient was discharged from the hospital two days later.

The T-tube was kept in place and clamped. On the 25th post-operative day injection of the T-tube was carried out without evidence of extravasation and as a result the T-tube was removed. Urinalysis showed scattered red blood cells and antibiotics were discontinued. The patient was maintained on urinary antiseptics. Six weeks post-operative a repeat urinalysis was negative and a drip infusion pyelogram was obtained showing good function bilaterally with moderate right hydronephrosis and hydroureter plus some slight narrowing at the anastomotic site. Six months post-operative a drip infusion pyelogram was repeated showing both kidneys functioning normally with less dilatation of the proximal third of the right ureter. The remainder of the ureter was entirely normal. Eighteen months post-operative the same studies were repeated. The studies showed normal renal function bilaterally, minimal dilatation of the right proximal ureter, adequate ureteral lumen at the anastomotic area with a normal distal ureter, (Fig. 6). The patient was discharged.

DISCUSSION

It is well established that the retrocaval ureter with minimal symptoms and nonprogressive hydro-



Fig. 4. T-tube splint and proximal ureterostomy.

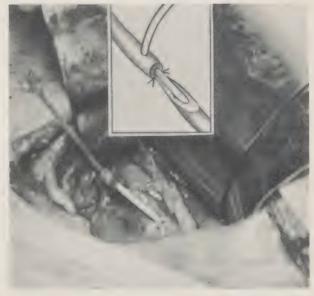


Fig. 5. Definite location of the T-tube coming out through proximal ureterostomy. Anterior and lateral ureteral defect is noted.



Fig. 6. Drip infusion pyelogram eighteen months post-operative. A, Anteroposterior film. B, Right posterior oblique film.

nephrosis free of infection, should be managed conservatively. Surgery should be contemplated only when symptoms are severe and progressive or when associated with repeated infections. Attempts should be made to re-establish normal renal function and nephrectomy done only if damage is so severe that improvement cannot be expected from corrective procedure performed on the ureter.

Several techniques have been advocated for the surgical correction of this anomaly. If the anomaly is not associated with ureteral stricture, pelvic division immediately above the ureteral pelvic junction (Harril) or eliptical sleeve resection of the renal pelvis and pelvic reanastomosis (Hynes) seems to be the procedure of choice since they avoid ureteral anastomosis and its danger of stricture formation. Division of the ureter at the urinary bladder junction with dissection up to the pelvic and ureteroneocystostomy (Lowsley) has shown poor results in that the devitalized ureter develops stricture or fistula.

When ureteral stenosis is present resection of the involved segment is necessary. Resection of the stenotic ureter and end-to-end anastomosis (Greene, Kearns, Nourse, Moody, Goyanna) or resection of the ureter distal to the affected area and ureteroneocystostomy has been used. Both techniques have inherent dangers. The first one tends to stricture formation and the second to fistula formation. This is usually secondary to poor blood supply of the extensively dissected ureter.

Division of the ureter above the site of compression and resection of the stenosed area with construction of a posterior flap of ureter with end-to-end anastomosis over a T-tube splint was the technique used by us in the present case which we believe to be the first one in the repair of retrocaval ureter.

Division of the vena cava and transposition of the ureter (Cathro) had been used in cases of solitary kidney or bilateral anomalies.

SUMMARY

A case of successful repair of a retracaval ureter has been presented with follow-up of the patient over a period of 18 months showing definite radiological improvement and no evidence of stricture formation with complete recovery of renal function on an asymptomatic patient.

A new technique for the surgical correction of this anomaly was introduced which is to be considered in future cases with a long stenotic ureteral segment.

BIBLIOGRAPHY

Considine, J.: Retrocaval ureter. Review of the literature with a report of two new cases. *Brit. J. Urol.*, Vol. 38:413, 1966.

Creevy, C. D.: Recognition and surgical correction of retrocaval ureter. *Amer J. Urol.*, Vol. 60:26, 1948.

Lowsley, O. S.: Postcaval ureter. Description of a new operation for its correction. Surg., Gny. and Obst., Vol. 82:549, 1946.

Shearer, T. P.: Retrocaval ureter. Report of a case with successful repair. *J. Urol.*, Vol. 62-152, 1949.

Laughlin, U.: Retrocaval ureter associated with solitary kidney. J. Urol., Vol. 71:195, 1954.

Brooks, R., Jr.: Left retrocaval ureter associated with situs inversus. J. Urol., Vol. 88:484, 1962.

Campbell, G. D., Anderson, J. C.: Retrocaval ureter, Aust. and N. Zealand J. Surg., Vol. 35:41-51, 1965.

Bitker, M. P.: Reflection on retrocaval ureter. Three previously unreported cases and review of literature. J. d'Urologie et Nephrologie, Vol. 71:851-863, 1965.

Mullen, W., Jr., Engel, W.: Circumcaval ureter. Radiology, Vol. 59:528, 1952.

Abeshouse, B. S., Tankin, L. H.: Retrocaval ureter. Report of a case. *Amer. J. Surg.*, Vol. 84:-383, 1952.

- Derrick, F. C., Jr., Price, R. Jr., Lynch, K. M., Jr.: Retrocaval ureter, J. So. Carolina Med. Assoc., Vol. 62:131-136, 1966.
- Cathro, A. J.: Section of the inferior vena cava and Retrocaval ureter. *J. Urol.*, 67: 464-475, 1952.
- Rognon, L. M., Pillet, J.: Cavography in the preoperative diagnosis of retrocaval ureter. J. d'Urologie et Nephrologie, Vol. 71:937, 1964.
- Lofgren, L., Heikkinen, E.: Retrocaval ureter. Annal. Chirur, et Gyn. Fenniae, Vol. 55:46, 1966.
- Brito, R. R., deMagalhaes, C. W.: Retrocaval ureter. Presentation of three cases. *Med. Cir., Farmacia*, Vol. 297:32-39, 1962.
- Fujii, Y., Sasabe, S., Araki, T.: Retrocaval ureter associated with polycystic disease of the kidneys. *Acta Urol. Japonica*, Vol. 12:1422, 1966.
- Dufour, A., Sesboue, P.: L'uretere retrocave, J. D'Urol., Med. et Chirurg. (Paris), Vol. 58:433-446, 1952.

- Dufour, A.: L'ureter retrocave. Bull Acad. Nation. de Med. (Paris), Vol. 147:522-529, 1963.
- Brizon, J., Delaneau, J.: A propos d'un nouveau cas d'uretere retrocave. *J d'Urol. et Nephrol.* (Paris), Vol. 67:293-299, 1961.
- Deliveliotis, A., Varkarakis, M.: Trois cas d'uretere retrocave. J. d'Urol. et Nephrol. (Paris), Vol. 70:365-370, 1964.
- Hradcova, L., Kafka, U.: Retrocaval ureter in childhood. *Urol. Intern.*, Vol. 16:103-116, 1963.
- Saika, H., Moriwaki, H.: A case of retrocaval ureter treated with vesicoureteroneostomy. *Acta Urol. Japonica*, Vol. 10:730-734, 1964.
- Revol, M.: A case of retrocaval ureter with lithiasis, J. d'Urol. et Nephrol. (Paris), Vol. 72:749-752, 1966.
- Hyans, B. B., et al.: Retrocaval ureter. Canad. Med. Assoc. J., Vol. 98:45-49, 1968.
- Anderson, J. C. and Hynes, W.: Retrocaval ureter. Brit. J. Urol., 21:209-14, 1949.



MONTHLY SURVEILLANCE REPORT CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH FOR THE FOUR-WEEK PERIOD ENDING SEPTEMBER 26, 1969

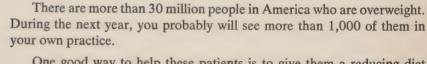
	1969 This 4-Week Period	1968 Same 4-Week Period	1969 Total To Above Date	1968 Total Same Date	Total Cases for 1968
Rubella	64	84	3,800	1,534	1,953
Measles	31	8	289	272	352
Whooping Cough	31	37	118	347	429
Diphtheria	_	_	_	_	
Mumps	80	93	3,984	13,196	14,655
Scarlet Fever &					
Strep Sore Throat	314	302	6,767	7,547	10,101
Tetanus	1		4	_	5
Poliomyelitis (paralytic)			_	oumnom.	3
Hepatitis	230	200	2,282	1,576	2,356
Salmonellosis					
(Other than S. typhi)	42	40	401	482	614
Typhoid Fever (S. typhi)			4		1
Shigellosis	26	26	210	193	346
Aseptic Meningitis	34	105	106	155	265
Encephalitis	19	14	92	68	114
Meningococcic Meningitis		6	92	73	94
H. Influenzal Meningitis	3	2	44	39	64
Tuberculosis	97	236	1,590	2,122	2,647
Syphilis	276	377	3,133	4,048	5,351
Gonorrhea	1,853	1,496	13,868	13,384	18,153

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director Michigan Department of Public Health



Let's be specific about Campbell's Soups... and reducing diets



One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to: Campbell Soup Company, Box 265, Camden, N. J. 08101



NOW IS THE TIME... TO GIVE HER TIME... WITH OVULEN-21°

Each tablet contains ethynodial diacetate 1 mg., mestranol 0.1 mg.

The new mother needs time... to adjust to motherhood, to give her new baby all the love and attention he requires. She needs time for her husband... and for herself as well... so that she can come to terms with the increased cares and responsibilities now facing her. She needs time to decide when she will have additional children and how many she will have.

Each tablet contains ethynodial diacetate 1 mg., mestranal 0.1 mg.

Your prescription for Ovulen-21 gives the new mother time to meet her family's present needs...to plan for her family's future.

She can take Ovulen-21 confidently and comfortably month after month. Its dependability is enhanced by its simplicity of use. A woman needs little or no time to learn the simple Ovulen-21 regimen: three weeks on—one week off. And the automatic record-keeping of the petite, virtually "patient-proof" Ovulen-21 Compack® helps to maintain her schedule...helps put time on her side,

Immediately post partum is the time

It is the time when motivation is highest—when a new mother needs expert advice for the future, so she can space her children and limit her family.

It is also the most opportune time, since she is conveniently present in the hospital, for her to be given both instructions and a prescription.

Non-nursing mothers may begin Ovulen-21 immediately after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended that nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Indication-Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968^{1,2} estimate there is a seven-to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboem-

DOILC	Disease in Users and	Non-Users	of Oral Cont	raceptives in Britain.
	Category	Mortali	ty Rates	Hospitalization Rates (Morbidity)
		Age 20-34	Age 35-44	Age 20-44
User	s of Oral Contraceptives Non-Users	1.5/100,000	3.9/100,000	47/100,000 5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contra-

ceptives has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither con-

firmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching. The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T³ uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see complete prescribing information.

Where "The Pill" Began
G. D. SEARLE & CO., P.O. Box 5110, Chicago, III. 60680

SEARLE

What's Polycillin (ampicillin) got to do with the price of bananas?

Just this: According to the U.S. Bureau of Labor Statistics, bananas are one of the few things that actually cost less today than five years ago. The same is true of Polycillin. In fact, the price of Polycillin has been reduced about 30% since its introduction in 1963...making it, according to national surveys of patient costs, as economical as leading brands of tetracycline and erythromycin.

And Polycillin is available in a variety of dosage forms for your patients—more than any other ampicillin. It comes in 250 mg, and 500 mg, capsules; in convenient, chewable tablets of 125 mg; oral suspension, 125 mg. and 250 mg. per 5 ml.; and in pediatric drops, 100 mg. per ml. Also available parenterally as Polycillin-N (sodium ampicillin).

BRISTOL LABORATORIES
Division of Bristol-Myers Co
Syracuse, New York 13201



Michigan Mediscene

Nov. 5 – MSMS Council, MSMS Headquarters, East Lansing, 9:30 a.m.

Nov. 9 – Michigan State Medical Assistants Society, MSMS Headquarters, East Lansing, 11 a.m.

Nov. 19-21 – American College of Emergency Physicians Scientific Assembly, Denver, Colo.

Nov. 20 – Lansing Dietetic Association, MSMS Headquarters, East Lansing, 7 p.m.

Nov. 30-Dec. 3 – AMA 23rd Annual Clinical Convention, Deputer, Colo.

vention, Denver, Colo.

Jan. 18 – Michigan Academy of General Practice Board Meeting, MSMS Headquarters, East Lansing, 2 p.m.

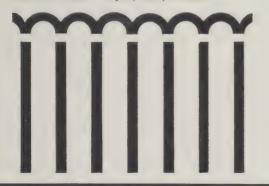
March 25-26 – MSMS and Clara Elizabeth Fundsponsored Maternal Health Conference, Flint

April 12-18 — Michigan Nurses Week May 11-16 — Michigan Hospital Week

COMMITTEE CALENDAR

Every month many MSMS committees meet to develop new projects and to move along projects approved by The Council or suggested by the House of Delegates. Following is a calendar of October, November and December meetings for the MSMS Council, MSMS committees and other official groups.

Wednesday, Nov. 5
MSMS Council
MSMS Headquarters, East Lansing
Chairman: Ross V. Taylor, M.D., Jackson
Wednesday, Nov. 12
MSMS Committee on Cancer
MSMS Headquarters, East Lansing
Chairman: M. E. Dodds, M.D., Flint
Wednesday, Nov. 12
Michigan Cancer Coordinating Committee
MSMS Headquarters, East Lansing
Chairman: C. Fred Arnold, Detroit
Wednesday, Dec. 10
MSMS Council
MSMS Headquarters, East Lansing
Chairman: Ross V. Taylor, M.D., Jackson



OUR STATE SOCIETY

State Med Journals Called Good Medium For Medical Advertising

State medical journals are a good medium for pharmaceutical advertising despite several problems, says the representative of a national medical advertising firm.

Erwin Gerson of Medical Media Associates of Chicago, recently addressing editors of state medical journals from throughout the United States, said, "despite the problems of advertising in a state medical journal, I believe in the state journals. I believe in the local approach to physicians."

Mr. Gerson's Medical Media Associates is an affiliate of the State Medical Journal Advertising Bureau of Chicago and helps advertisers place ads in the 34 state medical journals served by the SMJAB.

The problems posed to advertisers who wish to place messages in state medical journals, said Mr. Gerson, include the difficulty of judging the quality each month of 34 different journals and exclusion of West Coast states' medical society journals from the SMJAB group.

Mr. Gerson encouraged the state medical journal editors to seek local advertising, especially that of banks, insurance companies, fur houses and jewelry firms, for additional advertising revenue.

He enumerated the advertising problems of pharmaceutical houses as 1) the rising cost of the mass journals which requires that the advertising costs rise, also, 2) the proliferation of medical journals which makes the pharmaceutical houses prepare more advertisements for smaller audiences, 3) expiring patents on the names of new drugs which remove their uniqueness and reduce the advertising for them, 4) the lack of new pharmaceutical products, 5) more experimentation in the audio-visual advertising fields, 6) Federal Food and Drug Administration regulations requiring disclaimers with each drug ad, and 7) pressure from students and others on medical journals not to accept the advertising of certain pharmaceutical firms.



FOR MODERATE TO SEVERE ANXIETY WITH COEXISTING DEPRESSION

TRANQUILIZER-ANTIDEPRESSANT

Containing perphenazine and amitriptyline HCI

TRIAVIL®2-25: Each tablet contains 2 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL®4-25: Each tablet contains 4 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL®2-10: Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

TRIAVIL®4-10: Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; urinary retention; pregnancy; glaucoma. Do not give in combination with MAOI drugs because of possible potentiation that may even cause death. Allow at least 2 weeks between therapies. In such patients therapy with TRIAVIL should be initiated cautiously, with gradual increase in the dosage required to obtain a satisfactory response.

WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be potentiated.

PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed as its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

SIDE EFFECTS: Similar to those reported with either constituent alone.

Perphenazine: Should not be used indiscriminately. Use caution in patients with history of convulsive disorders or

severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; severe acute hypotension (of particular concern in patients with mitral insufficiency or pheochromocytoma); skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); grand mal convulsions; cerebral edema; altered cerebrospinal fluid proteins; polyphagia; paradoxical excitement; photophobia; skin pigmentation; failure of ejaculation; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia; significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol), atropine, heat, and phosphorous insecticides.

Amitriptyline: Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea; excitement; hypotension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, blurring of vision, urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

For more detailed information consult your Merck Sharp and Dohme representative or see the package circular.

MERCK SHARP & DOHME
Division of Merck & Co., INC., West Point, Pa. 19486
where today's theory is tomorrow's therapy

The following is the text of the talk given by A. Stewart Kerr of Detroit, Legal Counsel to the Michigan State Medical Society, during a special program at the Thursday morning session of the 1969 annual MSMS scientific session.

The Professional Service Corporation In Michigan

BY A. STEWART KERR MSMS LEGAL COUNSEL

There was, as you may know, an opinion by the Judicial Council of the American Medical Association in November, 1968, that it is ethically permissible for M.D.'s to form professional service corporations. The opinion of the Judicial Council requires, as Michigan Law does, that ownership and management of the affairs of the professional corporation remain directly and solely under the control of licensed physicians. The opinion goes on to state that the ethical principles for medical practice conducted as a professional service corporation are exactly the same as those for individuals and that an attending physician remains responsible for his patients. When medical practice is conducted under the form of a professional service corporation each physician member of the corporation must observe and follow all of the principles of medical ethics.

What is a professional service corporation in Michigan?

Under the Michigan Professional Service Corporation Act, A professional service corporation (P.C.) is a corporation organized for the *sole* purpose of rendering a professional service. In the case of a P.C. organized for conducting of medical practice, it may have as its shareholders only those individuals who are licensed by the State to render the medical services (and, for a short period of time, the personal representative for the estates for such individuals). Except as specifically provided in the Professional Service Corporation Act, a P.C. is governed by the general corporation laws of Michigan.

THE CORPORATE NAME must contain the words "professional corporation" or the common abbreviation "P.C." Although a medical P.C. may not engage in any other business than the practice of medicine, there is nothing to prevent a P.C. from investing its monies in real estate, stocks, bonds or other investments or owning real or personal property necessary or incidental to rendering of such medical services. The shares of stock of a P.C. are transferable only to other individuals who are eligible to be shareholders. Although the personal representative of a deceased shareholder may own for a reasonable period, he is not authorized to participate in any decisions concerning the

rendering of medical service; in effect, the personal representative is a mere investor with the right to receive the profits of the operation but not to direct or render any professional service. P.C.'s, like other corporations, may have other, additional restraints on the alienation of shares and provide for the redemption of shares as other corporations.

Under the Michigan Professional Service Corporation Act, the P.C. is liable up to the full value of its property for any wrongful or negligent act or misconduct committed by any of its officers, agents or employees while they are engaged in rendering professional services on behalf of the P.C. Thus, while the corporation's liability is limited to its assets, the Professional Service Corporation Act does not restrict or limit the liability between the attending physician and patient arising from their relationship. Any such officer, agent or employee of a P.C. remains fully and personally liable and accountable for any negligent or wrongful acts committed by him (or any other) person under his direct supervision and control) while rendering professional service on behalf of the corporation.

A P.C. is not governed as a partnership association but rather by a Board of Directors in the same manner as any other corporation. The Board of Directors may consist of less than the number of shareholders and this is generally advisable in large groups when one of the benefits sought is centralized management.

A P.C., like any other corporation, must file an annual report to the State of Michigan listing the names and addresses of all the shareholders, with a certification that all shareholders are duly licensed and authorized to practice medicine.

As noted in your various professional publications, the Treasury Department in August bowed to numerous recent court decisions and concluded that "organizations of doctors, lawyers, and other professional people organized under State Professional Association Acts will, generally, be treated as corporations for tax purposes." The method of the I.R.S. concession was that the Solicitor General did not ask the Supreme Court to review two recent Appeals Court rulings which granted corporate tax treatment to professional corporations. This means that the Court of Appeals rulings will stand as law and that the benefits and the ad-

vantages long sought by incorporations are now, at least for the moment, apparently available for all.

THE CAUTION LIGHT has, however, not changed to green - the concession was qualified ("generally") and, - one of the major benefits of incorporation for professionals, that is to have tax on pension plan contributions deferred until retirement may be substantially reduced by the proposed Nixon Tax Reform Bill. One proposal of the Tax Reform Bill will limit the tax deductions on retirement plans for some professional corporations to bring them in line with the more restricted allowances of a "Keogh" or "HR-10" retirement plan. It is proposed that, if an enterprise with ten or fewer shareholders incorporates for business purposes but wants to be taxed as a partnership (that is, as a so called pseudo or Subchapter S corporation) then it will be subject to the same tax treatment and limitations as an HR-10 pension plan. Thus, if the corporation elects to be treated as a partnership for income tax purposes it will be taxed as a partnership for retirement or pension plan contributions.

One important effect of this is that retirement contributions are subject to a tax deduction limited to 10% of the earned income or \$2500.00 whichever is less. These restricted rules have not applied to corporations to date. The I.R.S. also intends to go even further and limit the pension plans of all Professional Service Corporations in the same manner. This would, in effect, permit I.R.S. to accomplish by administrative legislation what it has been unable to do in the courts. It is a development that any one contemplating a P.C. will wish to keep informed on.

Before we begin our discussion of the advantages and disadvantages of practicing medicine as a P.C., we should expand a little on the tax implications discussed a moment ago. As we talked about, there has been a recent I.R.S. ruling conceding that organizations of doctors organized under state Professional Association Acts will, generally, be treated as corporations for tax purposes. One of the decisions directly affected by the I.R.S. ruling is the so called "O'Neill" case which arose in Ohio under the Ohio Professional Service Act. The Michigan Professional Service Corporation Act appears in substance, to be quite similar to the Ohio Act, and, accordingly the tax status of Michigan P.C. has been greatly cleared up by the ruling in Ohio. As in Ohio, the principal difference between an ordinary business corporation and a P.C. is that only licensed professionals can be stockholders. A second difference is that a P.C.'s services can only be rendered by a licensed professional or personnel supervised by them. Accordingly, an important corporate attribute of "limited liability" is substantially the same for Michigan and Ohio P.C.s since, in Michigan, as in Ohio, shareholders are not subject to personal liability for claims (other than wage claims in certain situations) against the corporation. In neither Ohio nor Michigan is the law applicable to the relationship between the person performing the professional service and the patient modified by practice as an employee of a P.C. The other "corporateness" attributes of free transferability, centralized management and continuity of life are, again, substantially the same in both the Ohio and the Michigan statutes and I believe, indicate that a Michigan P.C. is entitled to the same tax treatment as the Ohio P.C. in the O'Neill case.

LET US LOOK first at the non-tax advantages of practicing medicine in a P.C.:

First: As mentioned earlier, a P.C. has, to some degree, the attribute of limited liability.

Second: P.C.s have other corporate characteristics such as continuity of existence, free transferability of ownership of shares and continuity in holding title to property, as well as centralized management.

Third: P.C.s involve certain formalities such as the keeping of orderly records and minutes and, therefore, can be a utilitarian vehicle for conducting business affairs. As a P.C. will be centralizing its business management in its Board of Directors and, perhaps, in an Executive Committee, only the Executive Committee and the business manager need worry about most business matters and thus relieve the other associates of annoying business details.

Fourth: P.C.s are more manageable in connection with estate planning and probate matters than are partnerships and proprientorships. P.C.s provide a relatively simple vehicle for the sale of professional practices from the older to the younger members with favorable tax treatment, provisions of the funds with which to do it and the setting up of definite valuation procedures for a practice, all of which make estate planning and probate an easier matter to organize and anticipate.

Fifth: P.C.s do not terminate, as do partnerships, on the death, retirement, or addition of a member.

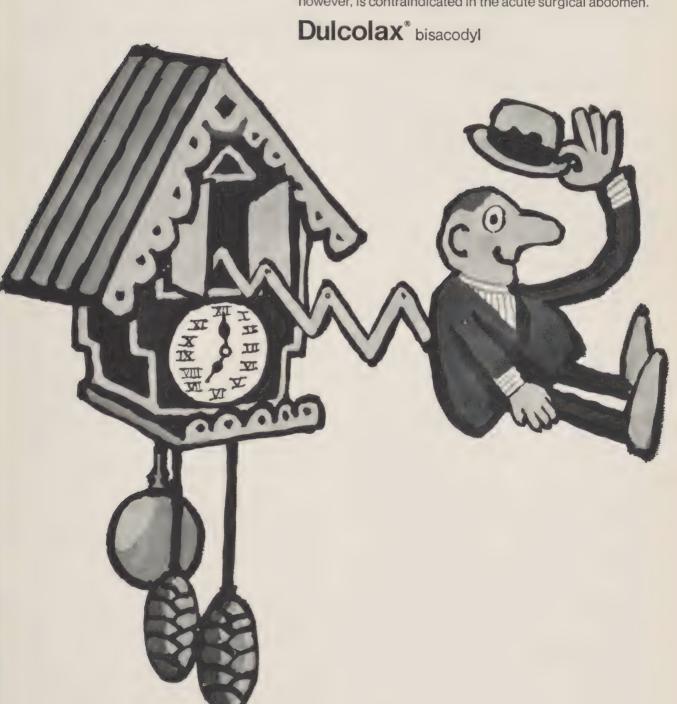
The primary benefits of practicing medicine as a P.C. involve the tax benefits to employees from pension and profit sharing plans. These benefits are available, of course, only if the principals involved decide that they are willing to defer income to later periods. If you intend to withdraw all the income from the operation in current salaries, these pension benefits would be of little or no consequence and one of the chief advantages of P.C.s would be missing. The primary tax benefits of P.C.s are the following:

Dulcolax...so predictable you can almost set patients by it.

Dulcolax works so effectively that the time of bowel evacuation can often be predicted.

Dulcolax tablets taken at night will usually result in a convenient bowel movement the following morning. Dulcolax suppositories generally work within 15 minutes to an hour.

Dulcolax may be given to the aged, pregnant or nursing women, and children. It may be particularly helpful in conditions in which straining should be avoided. The drug, however, is contraindicated in the acute surgical abdomen.



- 1. Employees of P.C.s can benefit from pension and profit sharing plans. The benefits of such plans are too numerous to mention in this brief talk but the more important are: (a) There is an immediate tax deduction for the P.C. for its contributions to the plan so that the actual cost (based on a P.C. in the 52.8% post surcharge bracket) will only be \$.47 per dollar contributed; (b) if the pension plan is funded by life insurance the premiums are, in effect, deductible expenses; (c) the pension trust is, itself, exempt from tax, and it can accumulate income much more rapidly than can an entity subject to income tax; (d) there is an estate tax exemption on survivorship benefits if received from a qualified plan. The advantage to the employees on distribution from a qualified pension plan are likewise too numerous to discuss completely but the major ones are: (a) distributions are taxed only as received when, presumably, the recipient will be retired and in a lower tax bracket; (b) in computing the retirement income credit, a pension or annuity is not considered "earned income"; (c) the employee can get back his contributions to the plan tax free for the first three years if received as an annuity; (d) distribution received after an employee reaches age 65 will benefit from the double exemption at that age; and (e) most importantly, the distributions may be treated as a capital gain if received in one taxable year.
- 2. Corporate employees may receive payment from accident, health and sickness insurance plans tax free where the insurance is paid for by the P.C.
- 3. P.C.s may adopt medical expense reimbursement plans which, in substance, permit the deduction of medical expenses without the 3% limitation;
- 4. P.C.s may adopt wage continuation plans whereby the costs paid directly by the P.C. or paid as a premium for disability insurance are deductible by the P.C. and the benefits received by the disabled employee (subject to certain limitations) are excluded from his income.
- 5. The benefits from group term life insurance plans are tax free to the employees.
- 6. Employees of P.C. receive the benefit of social security premiums tax free.
- 7. Employee death benefits to P.C. employees up to \$5,000 are exempt from tax.
- 8. P.C.s have free choice of a fiscal year. A partnership must be in the same taxable year as the majority of its partners; thus, a P.C. may achieve certain tax advantages by adopting a fiscal year and fixing salaries and bonuses at an "optimum" level by careful timing.
 - 9. P.C. employees may obtain benefits of defer-

- red compensation plans which can spread or postpone income to later years. The extent of these benefits may, however, be affected by certain of the provisions of the proposed Tax Reform Bill in Washington.
- 10. Stock options and stock bonuses are available to corporate employees. This also has the non-tax benefit of being a method of bringing in new and younger members to the group.
- 11. P.C. income is taxed (before accounting for the surcharge) at the rate of 22% on the first \$25,000 of income and at the rate of 48% thereafter. However, corporate income is theoretically taxed "twice" when distributed as dividend income.
- 12. P.C.s are allowed to deduct 85% of the dividends which are received from other domestic corporations. Thus, without taking into account the surcharge, the effective rate on dividends received from other corporations is only 7.2% when the corporate rate is 48%.
- P.C.S DO PRESENT a number of problems. Most of their disadvantage can be avoided by careful advanced planning. Major problems which may arise include the following:
- 1. The possibility of a surtax on accumulated profits over \$100,000. The solution of this problem is simply not to accumulate that much or have a good business reason for doing so.
- 2. A deduction for "unreasonable" compensation may not be allowed. To justify the deduction, salary income must be earned; otherwise any portion of "compensation" will be deemed to be a non-deductible dividend by the corporation.
- 3. There may be a taxable transaction at the time of the organization of the P.C. if it is not a transfer to a so called "controlled corporation"; that is, if the individuals owning the property transferred to the P.C. do not end up owning more than 80% of the new corporation.
- 4. There may be, at the time if incorporation, a tax on the unrealized receivables transferred to the new P.C. This may be avoided by keeping the old partnership alive until those items are collected; otherwise, there may be serious bunching of income.

P.C.s may not qualify for the optional tax treatment as a partnership in the form of a small business corporation under Subchapter S (pseudo corporations) since it is thought by some to detract from the "corporateness" of a P.C. In addition, as discussed before, the proposed Tax Reform Bill includes restrictions which would limit the benefits a Subchapter S corporation could realize from a pension plan and subject its pension plan to those requirements in limitations of a "Keogh" or "HR-10" plan.

AS TOUCHED UPON throughout this talk, the primary tax benefit of P.C.s is the opportunity, at least for the present, to take advantage of corporate pension plans. Such a plan should be compared to the recently revised retirement benefit plans available to the self employed individuals, including partners, known as the "HR-10" or "Keogh" Plans. In discussing these Plans, the terms "owner-employee" refers to persons who own more than 10% of the income or capital and "self employed persons" refers to those persons who own the right to less than 10% of the income. The benefits and detriments of an HR-10 Plan as compared to a standard corporate pension plan may be summarized as follows:

- 1. Coverage: Under an HR-10 plan all full time employees employed for more than three years must be covered by the plan. Under a standard corporate pension plan, the same selection is permitted but not required: other non-discriminatory qualifications may be used.
- 2. Contributions: Under an HR-10 plan contributions may not exceed \$2500.00. Under a corporate pension plan, a reasonable % of an individual's compensation may be contributed to a pension plan and still deductible to P.C.; even this may be increased by integrating a profit-sharing plan with the pension plan.
- 3. Excess contributions: Under an HR-10 plan there is a penalty for excess contributions for the benefit of a "owner-employee" whereas under a corporate pension plan there is no penalty other than non-deductibility.
- 4. Vesting: Under an HR-10 plan there must be an immediate 100% vesting of all contributions and earnings. Under a corporate plan, various provisions can base the vesting to years of service and various other non-discriminatory tests more advantageous to the P.C.
- 5. Definite contributions: Under an HR-10 plan there must be a plan which definitely sets out the contributions to be made. Under a corporate pension plan, contributions can be discretionary and can vary from year to year (within certain I.R.S. limits).
- 6. Distributions: Under an HR-10 plan the most advantageous tax benefit will require a five year pay out under the annuity rules. Under a corporate pension plan, there can be capital gains treatment if the distribution is made in a lump sum.
- 7. Distribution Limits: Under an HR-10 plan the distribution must occur between the ages 59½ and 70½, whereas, under a corporate plan the time restriction depends on the plan itself.
- 8. Distributions: The standard corporate distributions are free of gift and estate tax whereas HR-10 plan distributions have no estate tax exemptions.

- 9. Borrowing: Under an HR-10 plan there can be no borrowing from the trust by the "owner-employee" whereas under a corporate plan it is possible that there can be some borrowing by the P.C. from the pension trust if, in fact, adequate security is given for the loan.
- 10. Social Security: Integration with social security benefits may be accomplished to some extent, in both HR-10 plans and corporate pension plans.
- 11. Trustees: Under an HR-10 plan a bank must be a trustee whereas under a corporate plan there is no limit as to who may be a trustee. Thus, from this brief comparison, it is probably obvious to all of you that, without getting into the tedious details there is no question that the benefits of an HR-10 plan, as compared to a corporate pension plan, are minimal and that a corporation plan is considerably better.

BEFORE A P.C. is undertaken, it must first be decided that a corporation will provide the benefits that you are seeking. If the maximum benefits of deferred compensation and the other advantages of incorporation are desired incorporation should then be considered and you should consult your attorney and accountant to get their advice on exactly what the effect on your practice will be and whether or not it is desirable for you.

AMA Clinical Convention Scheduled In Denver Nov. 30

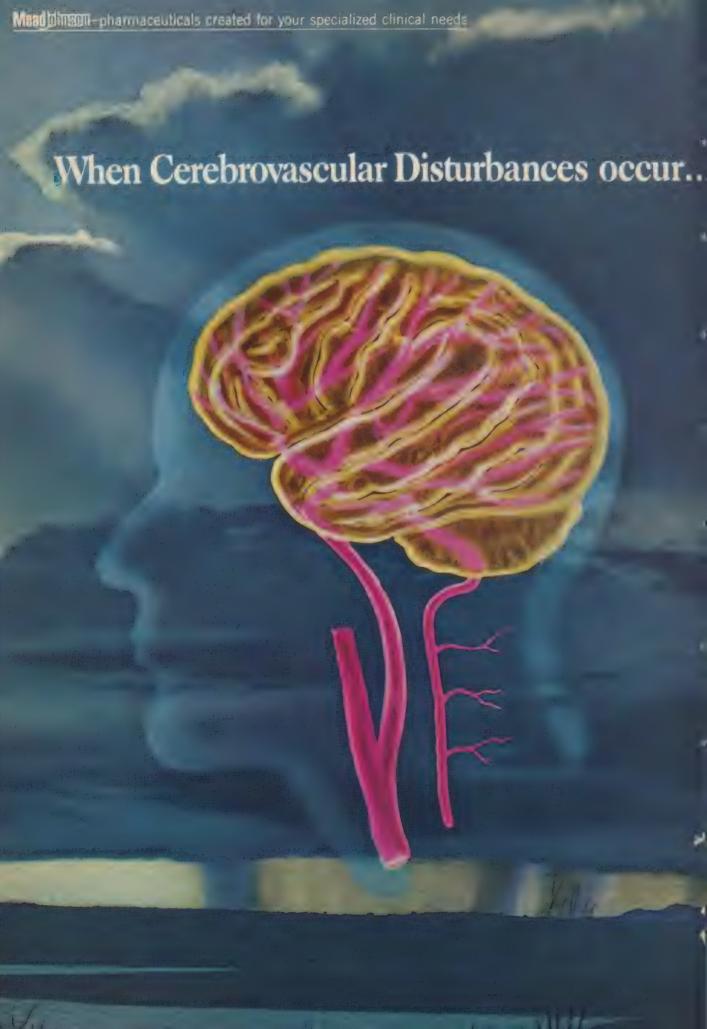
Many Michigan physicians will attend the American Medical Association's 23rd Clinical Convention in Denver, Nov. 30 through Dec. 3, the third to be held in The Mile-High City.

Scientific sessions are planned mornings and afternoons, Monday through Wednesday, covering the latest developments in a variety of areas including heart disease, cancer, and pulmonary problems.

Round-table sessions, previously conducted at breakfast gatherings, will be held over lunch at this year's Clinical Convention. Topics include the battered child, problems related to suicide, and human sexuality.

About 25 medical motion pictures will be shown, including several premiere showings.

The entire program was carried in the issue of The Journal of the American Medical Association dated Oct. 20.



...with episodes of vertigo, headache, confusion, sensory loss, slurred speech, consider

VASODILAN® (ISOXSUPRINE HCI)

to help relieve symptoms by preventing vasospasm and increasing cerebral blood flow



Although not all clinicians agree on the value of vasodilators in vascular disease,¹ several investigators²-5 have reported favorably on the effects of isoxsuprine on cerebral blood flow. Effects have been demonstrated both by objective measurement²-5 and observation of clinical improvement.²-4 linications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). Composition: VASODĪLAN tablets, isoxsuprine hydrochloride 10 mg. Dosage: Oral—10 to 20 mg. (1 or 2 tablets) t.i.d. or q.i.d. Contraindications and Cautions: There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. Side Effects: Occasional palpitation and dizziness can usually be controlled by dosage reduction. As intramuscular administration of 10 mg. or more may cause brief hypotension and tachycardia, single intramuscular doses exceeding this amount are not recommended. Complete details available in product brochure from Mead Johnson Laboratories References: (1) Fazekas, J. F.; Alman, R. W.; Ticktin, H. E.; Ehrmantraut, W. R., and Savarese, C. J.: Angiology 15:No. 2 (Feb.) 1964. (2) Horton, G. E., and Johnson, P. C., Jr.: Angiology 15:70-74 (Feb.) 1964. (3) Clarkson, I. S., and LePere, D. M. Angiology 11:190-192 (June) 1960. (4) Dhrymiotis, A. D., and Whittier, J. R.: Current Therapeutic Research 4:124-128 (April) 1962. (5) Whittier, J. R.: Angiology 15:82-87 (Feb.) 1964.

INGRAM'S SERVICE DEPARTMENT

ALL FACTORY TRAINED MEN

We service Medical Equipment, Electrocardiographs, Basal Metabalors, Sterilizers, Autoclaves, Diathermy Outfits, Cutting Units, Ultra Violet Lamps, Hydro Therapy Units, Laboratory Equipment. ALL BURDICK, LIEBEL FLARSHEIM AND RITTER EQUIPMENT.

If you have any Service problems, please call us at TE 2-4444, ask for the SERVICE DEPARTMENT and we will gladly help in any way we can.

THE G. A. INGRAM COMPANY

4444 Woodward Avenue

TEmple 2-4444

Detroit, Michigan 48201

Ec-ANTACID Your ulcer patients and others will appreciate it. Specify DICARBOSIL 144's-

144 tablets in 12 rolls.





In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Poderio LEDERLE LABORATORIES A Division of American Cyanamid Company, Pearl River, N.Y. One of these disposables comes prefilled. Its unit dose – in nonreactive glass cartridge – is premeasured. The cartridge is clearly labeled: drug name, strength, control number. Even expiration date where appropriate.

You're more confident that the patient gets...





... just what the doctor ordered with the Tubex Closed Injection System.

Injections with the Tubex system are as easy as 1, 2, 3,

- 1. Select—from an extensive variety of prefilled Tubex sterile cartridge-needle units.* No multi-dose vials to bother with; no unlabeled syringes to cause confusion.
- 2. Inject—with a minimum of pain. Thanks to the single-use, stainless-steel needle that's both ultrasharpened and siliconized. Aspirate simply and conveniently.
- **3. Throw away**—empty cartridge-needle unit. Never used again, it can't transmit infection. And there's no clean-up job.

*For injectables not yet in the ever-expanding prefilled Tubex line, empty sterile cartridge-needle units are available.

TUBEX®

Closed Injection System
Hypodermic Syringe
Sterile Cartridge-Needle Unit





Wyeth Laboratories Philadelphia, Pa.

More 1969 MSMS Annual Session Photos

(FIRST PHOTOS APPEARED IN OCTOBER NEWS EXTRA)



VOLUNTEER PHYSICIANS FOR VIETNAM were specially recognized before the Sunday evening opening meeting of the House of Delegates and at a dinner in their honor preceding the meeting. Presented in a body before the House are, from left, Hugh T. Caumartin, M.D., Saginaw; Franklin V. Wade, M.D., Flint; Hugh L. Sulfridge, M.D., Saginaw; Alfred B. Swanson, M.D., Grand Rapids; Lambertus Mulder, M.D., Muskegon, and Hira E. Branch, M.D., Flint, chairman of the MSMS International Health Committee.



NEWLY-ELECTED MEMBERS of The Council, MSMS's board of directors, shake hands spiritedly with Council Chairman Ross V. Taylor, M.D., Jackson, right. From left are Robert C. Prophater, M.D., Bay City; Ernest P. Griffin, M.D., Flint, and Robert M. Leitch, M.D., Union City. Newly-elected councilor not shown is Adam C. McClay, M.D., Traverse City.



MSMS PROUDLY RECOGNIZED these 10 veterans of 50 years of service as physicians to their fellow men. They were escorted to the front of the MSMS House of Delegates to a standing ovation, and later posed for this picture. From left are Joseph M. Croman, Jr., M.D., Mt. Clemens; Hyman L. Perlis, M.D., Detroit; Linwood W. Snow, M.D., Northville; Jose Guerrero, M.D., Detroit; Angus L. McDonald, M.D., Detroit; Harry L. Clark, M.D., Ludington; Lawrence S. Fallis, M.D., Detroit; Thomas Hoffer, M.D., Allen Park; Walter F. Bach, M.D., Dearborn Heights, and A. W. Pietra, M.D., Grosse Pointe.



A SPECIAL GUEST at early portions of the 1969 MSMS House of Delegates Annual Session was Ernest B. Howard, M.D., executive vice president of the AMA. Doctor Howard, who brought greetings from the AMA to MSMS, is shown ABOVE conferring with MSMS House of Delegates Vice Speaker Vernon V. Bass, M.D., Saginaw; and in informal conversation ABOVE RIGHT with, from left, MSMS President Robert J. Mason, M.D., Birmingham; MSMS Immediate Past President James J. Lightbody, M.D., Detroit and Chairman of the MSMS Delegation to the AMA, Donald N. Sweeny, Jr., M.D., Saginaw. Doctor Howard is interviewed, RIGHT, by Jean Pearson, science writer for the **DETROIT NEWS**.





THE NEW ADMINISTRATION leaders of MSMS for 1969-70 are Harold B. Hiscock, M.D., Ypsilanti, left, named president-elect during the 1969 Annual Session, and Robert J. Mason, M.D., Birmingham, installed as president.







MICHIGAN'S SAMA CHAPTERS were represented at the 1969 Annual Session, by, from left above, Hassney Hamood, junior class president and Ched Hikes, vice president of SAMA, both from Wayne State University, and Lynn Cooper, SAMA president and Thomas O. McNett, SAMA vice president, from Michigan State University. The quartet was seated with the MSMS House of Delegates throughout the three-day meeting. At left, Ken Hekman, of Wayne State University, a member of the national SAMA Council on Medical Education, talks with Geoffrey Brinkman, M.D., Detroit, chairman of the Thursday general luncheon during the Scientific Session, at which Ken was the featured speaker.



PRESIDENTIAL DUTIES PASSED from the hands of Mrs. Earl E. Weston, Birmingham, immediate past president, left, to Mrs. Edward Maxim, St. Clair Shores, right, new president of the Woman's Auxiliary to the Michigan State Medical Society. Conducting the installation of new officers during the Auxiliary convention Oct. 1 and 2 at the Pontchartrain Hotel, Detroit, was Mrs. John M. Chenault, Decatur, Alabama, center, president of the Woman's Auxiliary to the American Medical Association.



PAST PRESIDENT'S PIN was presented by MSMS House of Delegates Speaker James B. Blodgett, M.D., Royal Oak, right, to Kenneth H. Johnson, M.D., Lansing, MSMS Secretary, in a surprise ceremony during Monday night's House of Delegates meeting.

Congeniality Marks Annual Past Presidents' Dinner

THE CONVIVIALITY of the MSMS Past President's party at the Annual Session is summed up by the meeting of two former MSMS presidents, Bradley M. Harris, M.D., Ypsilanti, left, who served in 1967-68, and L. W. Hull, M.D., Brighton, whose term spanned 1953-54.

MICHIGAN PHYSICIANS focus their attention on an out-of-state visitor, Robert N. Smith, M.D., president of the Ohio State Medical Association, second from left, during the formal get-together of the Past President's Dinner. From left, others are MSMS Past President, Oliver B. McGillicuddy, M.D., Lansing and G. B. Saltonstall, M.D., Charlevoix, and new MSMS President Robert J. Mason, M.D., Birmingham.







INFORMAL PORTRAIT of MSMS members at Past Presidents' Dinner catches, from left, John S. DeTar, M.D., Milan; Oscar D. Stryker, M.D., Mt. Clemens; MSMS Secretary Kenneth H. Johnson, M.D., Lansing, and MSMS Immediate Past President James J. Lightbody, M.D., Detroit. Both Doctor DeTar and Doctor Stryker are former speakers of the MSMS House of Delegates.



SEVERAL MIDWESTERN states sent officers of their medical societies to the 1969 MSMS Annual Session. Among the visitors at the Past Presidents' formal dinner was J. Ernest Breed, M.D., president-elect of the Illinois State Medical Association, who chatted with Ross V. Taylor, M.D., chairman of The MSMS Council.



PAST PRESIDENTS of MSMS get together for this dinner pose. They are Luther R. Leader, M.D., Royal Oak, left, who served in 1965-66 and Otto K. Engelke, M.D., Ann Arbor, president in 1961-62.



GOOD STORY is told by D. Bruce Wiley, M.D., Lansing, right, to the amusement of Hugh W. Brenneman, left, MSMS executive director, and Otto O. Beck, M.D., Birmingham, past MSMS president, as they attend Past Presidents' Dinner. Doctor Wiley is a past secretary and past Council chairman.

Presidents of National Medical Organizations Recognized



Chris J. D. Zarafonetis, M.D., Ann Arbor American Society of Clinical Pharmacology and Chemotherapy American Therapeutic Society

SEVEN MICHIGAN DOCTORS who are presidents of national medical organizations were honored during the MSMS House of Delegates annual session in Detroit Sept. 28-30 with the presentation before the general meeting of a framed certificate. Among them were the four physicians shown here, receiving their awards from MSMS Immediate Past President James J. Lightbody, M.D., Detroit. Others, not pictured, include Duane L. Block, M.D., Dearborn, president of the Industrial Medical Association; Donald J. Jaffar, M.D., president of the American Urological Association; and William B. Weil, Jr., M.D., East Lansing, president of the Society of Pediatric Research



Raymond W. Waggoner, M.D., Ann Arbor American Psychiatric Association



Clarence S. Livingood, M.D., Grosse Pointe American Dermatological Association



James Ferguson, M.D., Grand Rapids American Proctologic Society



A PLEASANT INTERLUDE to official House of Delegates proceedings took place when new MSMS President Robert J. Mason was presented with a framed citation from his alma mater, Rush Medical College. His proud alumni association, represented by fellow Detroit alumnus Harold Lampman, M.D., right, recognized Doctor Mason as an "outstanding, loyal alumnus" on the occasion of his inauguration as MSMS president.



ANNUAL SESSION HIGHLIGHTS included the early morning MDPAC breakfast Wednesday, with major speakers such as U. S. Sen. Philip A. Hart (D-Mich.), seated right. Among those present to hear Sen. Hart were, from left, Thomas M. Flake, M.D., Detroit; Robert J. Mason, M.D., Birmingham, new MSMS president, and Louis R. Zako, M.D., Detroit, MDPAC board member.

MDPAC Breakfast Features Congressmen

THE GOVERNMENT'S ROLE with medicine is to act as a catalyst, a synthesizer and an aid and to leave the expertise to medicine, declared U. S. Rep. Marvin Esch, (R-Mich.), seated right. He spoke at the MDPAC Breakfast Wednesday morning at the annual session and drew attention from, left to right, Kenneth E. Johnson, M.D., Lansing, MSMS secretary; Ross V. Taylor, M.D., Jackson, chairman of The MSMS Council, and Donato Sarapo, M.D., Adrian, MDPAC chairman.





TWO MSMS MEMBERS were part of an evening panel during the three-day physician-education course, "Decision-Making in Acute Coronary Care," presented in September by the Michigan Heart Association and MARMP at Towsley Center for Continuing Education, the U-M. The two physicians were, left, Malcolm K. Dolbee, M.D., Standish, national authority on community hospital coronary care units, and Gerald M. Breneman, M.D., Detroit, chairman of the Henry Ford Hospital Coronary Care Unit and chairman of the MHA Coronary Care Unit committee, third from left.



Michigan Heart Association Sponsors Three-Day Seminar for Physicians

CHATTING WITH Carl J. Olson, M.D., Escanaba, and Brooker L. Masters, M.D., Fremont, from left, are Condon R. VanderArk, M.D., and Ernest W. Reynolds, Jr., M.D., nationally known electronics expert, both of the Heart Station, U of M Medical Center, Ann Arbor. The latter two lectured at the Michigan Heart Association-Michigan Association for Regional Medical Programs three-day September physician-education course at the U of M's Towsley Center. Doctor Olson and Doctor Masters were among the 126 doctors who took the course, titled, "Decision-Making in Acute Coronary Care."



WITH THE LEGAL and medical professions increasingly crossing paths, Wayne State University's Schools of Law and Medicine have jointly begun a new Law and Medicine Seminar. Future practitioners tackle topics such as transplantation of tissues, determination of death, problems of proof in malpractice, medical evidence in court, medical and legal ethics and a host of other subjects of interest to both professions. Here Martin L. Norton, M.D., Southfield, left, associate professor of anesthesiology, listens as fellow instructor Grant H. Morris, Royal Oak, associate professor of law, lectures to the 32-member class, split evenly between law and medicine students.



unwelcome bedfellow for any patient-including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information - Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. Indications: For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. Contraindications: QUINAMM is contraindicated in pregnancy because of its quinine content. Precautions/Adverse Reactions: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. Dosage: One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. Supplied: Bottles of 100 and 500 tablets.



THE NATIONAL DRUG COMPANY DIVISION OF RICHARDSON-MERRELL INC PHILADELPHIA, PENNSYLVANIA 19144

Specific therapy for night leg cramps



Monilia emerging as a major therapeutic problem recent studies report increased incidence, attributed in part to the use of oral contraceptives, 1-4 broad-spectrum antibiotics 5-9 and prolonged use of corticosteroids. 7 recent evidence establishes high rate of microbiological and clinical cure with AVC.9-11

Comprehensive - Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfon-

amides.

Precautions/Adverse Reactions: The usual precaurecourtons, Adverse Reactions: The Usual precou-tions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue

Dosage: One applicatorful or one suppository intravaginally once or twice daily.

Supplied: Cream – Four-ounce tube with or without applicator. Suppositories – Box of 12 with applicator.

applicator.
References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec.

93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South, M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.



THE NATIONAL DRUG COMPANY PHILADELPHIA, PENNSYLVANIA 19144

CREAM (aminacrine hydrochloride 0.2%, sulfanilamide 15.0%, allantoin 2.0%)

SUPPOSITORIES (aminacrine hydrochloride 0.014 Gm., sulfanilamide 1.05 Gm., allantoin 0.014 Gm.)



BURROUGHS WELLCOME & CO. (U.S.A.) INC.

Tuckahoe, N.Y.



Because peripheral vasodilation is needed now... and must often be continued

Roniacol Timespan (nicotinyl alcohol tartrate) can make a significant contribution to effective treatment of peripheral vascular disorders. It is directed specifically toward improvement of peripheral blood flow, relief of ischemic symptoms, and the long-term management of these conditions.

Specific pharmacologic action—Roniacol (nicotinyl alcohol) acts selectively by relaxing smooth muscle of peripheral blood vessels. Onset of action is smooth and gradual, rarely causing severe-flushing.

Relative freedom from side effects—Side effects

that may occur occasionally with Roniacol seldom require discontinuation of therapy.

Prolonged, continuous drug release—Prolonged peripheral vasodilation is provided by sustained-release Roniacol Timespan (nicoting alcohol tartrate) Tablets. Part of the drug becomes available immediately, the remainder continuously over a period of up to 12 hours, and dilation of constricted peripheral vessels in usually maintained. Thus, with a single dose of medication, patients can enjoy the benefits of increased peripheral blood flow in ischemical extremities for up to 12 hours.



Smooth peripheral vasodilation from initial dosage...extended with simple, well-tolerated, b.i.d. dosage

The prolonged action of Roniacol Timespan nicotinyl alcohol tartrate) together with its other benefits offer a therapeutically practical neasure in the long-term management of eripheral vascular disease—advantages specially important for older patients.

efore prescribing, please consult complete roduct information, a summary of which ollows:

ndications: Conditions associated with eficient circulation; e.g., peripheral vascular isease, vascular spasm, varicose ulcers, ecubital ulcers, chilblains, Meniere's syntome and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt—bottles of 50 and 500.



Division of Hoffmann - La Roche Inc. Nutley, New Jersey 07110

Art is a conception of peripheral vasodilation.



Preludin[®] phenmetrazine hydrochloride

Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).

Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors. Warning: Do not use during the first trimester of

Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation.

Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.

Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.

Availability: Pink, square, scored tablets of 25 mg, for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.

Pink, round Endurets® prolonged-action tablets of 75 mg, for once-a-day adminis-

Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000. (B)R3-46-560-B

Under license from Boehringer Ingelheim G.m.b.H.

For complete details, please see full prescribing information.



Geigy Pharmaceuticals Division of Geigy Chemical Corporation Ardsley, New York 10502

For some, obesity can be a serious complication of moderate hypertension, diabetes, or pregnancy.

Preludin may be used to curb appetite in obesity associated with such conditions.

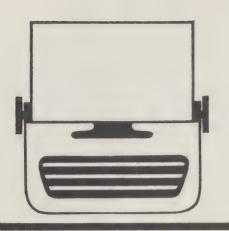
For use during pregnancy, please consult Warning paragraph. The use of Preludin in moderate hypertension should be accompanied by caution. In diabetes, the drug does not increase insulin requirements (requirements may be reduced as weight is lost).

One 75-mg. Endurets tablet taken between breakfast and midmorning will usually provide daylong and early-

evening suppression of appetite.

Preludin phenmetrazine Endurets prolonged

Endurets® prolonged-action tablets



EDITORIAL VIEWS

Fee-For-Service Concept In Dire Danger

BY BROOKER L. MASTERS, M.D. FREMONT

The National Health Insurance proposal seems almost incomprehensible to a private practitioner, carrying as it does a distinct aroma of that old anathema called the Murray-Wagner-Dingle Bill. But, illogical as it seems, I detect a ground swell towards a National Prepaid Health Insurance Program. I even hear the word "compulsory" attached to it.

This probably is originating in the planning halls of Washington, D.C., but there is also nationwide evidence for it in the press.

As everyone knows by now, the majority of citizens (voters?) have been sold on the idea that health care is a "right." The politicians have further sold the idea that this care must be equally available to all, regardless of ability to pay. This means that the poor will have their health program planned and financed by the government. As a corollary, it also appears to mean that the health planners will determine levels of health care for the middle class as well, and probably for everyone in the social order.

Ironic though it is, this pressure for a national prepaid plan seems to result from the experience with Medicare and Medicaid which once were considered substitutes for total compulsory participation. Additional irony is that the medical profession originally opposed Medicare and Medicaid as an ill-conceived political boondoggle.

Now, although performance proves these predictions correct, we see the incredible spectacle of socialist planners deciding that to retire Medicare and Medicaid in favor of a compulsory plan for everyone is the only way in which all can benefit from the scientific advances which have so revolutionized medical care in the past 25 years. By thus controlling the fees and services of doctors, the unbearable cost of medical care can be met.

The fallacy of this argument needs to be met head-on by pointing out the reasons why Titles 18 and 19 are in financial trouble in the first place.

The main concern in relation to these programs is indeed their rapidly rising cost.

This is a justifiable concern.

In published discussions of this cost, however, little space is given to the part of inflation, rising salary levels for all hospital and paramedical personnel, increased cost of modern life-saving techniques and modalities, the expanding population, the rising age level of the population, the increased demand of the consuming public.

No, it is basically you, doctor, who is responsible! These articles do not say outright that the higher cost of medical care is due to your increased fees, but the implication is there, for after all, you are the one who determines the degree and scope of that care. Therefore, the rising costs are your responsibility.

Are you with me?

Most of us are convinced that the fee-for-service concept is fundamental to the doctor-patient relationship. Many thinking patients know that medicine can never be an assembly-line operation. But in this era of limitless demand for health care services coupled with the unquestioned shortage of medical personnel, the public, untrained in means of judging quality medical care, is lumping all care together and becoming concerned only about the quantity of care available.

Quantity will be demanded more and more as the public is told on every side that it is their "right" to be able to consult a doctor at any time, and at a prepaid insurance level.

If you find it hard to believe that patients are ready to sacrifice quality for quantity, the politicians do not. They are listening and they are acting. They are proposing a National Compulsory Prepaid Health Insurance Program.

Who will deliver it?

The medical profession, of course. And how can that be done when we are all overworked now? By government controls, of course. And that will mean salaried physicians, government-set fee schedules, and a controlled profession from the ground up.

I, for one, think this result is inevitable. The shortage of medical personnel is so great, the demand of the public so insatiable, that these opposing forces simply cannot be reconciled in time



COUNTY SOCIETIES

INGHAM MDs STUDY EDUCATION, MALPRACTICE

Members of the Ingham County Medical Society heard a lecture on the trends in medical education by Hilliard Jason, M.D., Ed.D., director of the office of Medical Education, Research and Development, College of Human Medicine, Michigan State University, at their October meeting, and plan a Nov. 18 dinner meeting on "Liability—The Physician and the Hospital," with Alfred Julien, attorney, of New York City.

Doctor Masters On National Health Insurance

Continued from page 1176

to prevent the people from demanding and getting a national prepaid insurance program.

In short, the fee-for-service concept is in dire danger. It is possible that if the medical profession could unite, and if 95% of the profession were politically active and aware, ready to fight these changes, then something might be done to achieve another solution. But when only about 10% of physicians are concerned about the organizational side of their profession — and this is really the way it is — I do not foresee this unanimity.

Therefore, it seems to me that our immediate tasks are, first to recognize that fee-for-service is probably a concept that will go the way of the general practitioner; and second to work with the "planners" to find ways of extracting from the socialistic melange some practical ideals with which the followers of Hippocrates can live in future generations.

There is little doubt that we are few in number to combat the socialistic forces of 200 million people. Also little doubt that time is extremely short.

KALAMAZOO, WAYNE SOCIETIES TAKE STEPS TO ADMIT DOS

Both the Kalamazoo Academy of Medicine and the Wayne County Medical Society have taken recent steps to admit qualified doctors of osteopathy to their active membership lists.

The Kalamazoo Academy members at a September meeting voted to accept the recommendation of their Liaison with Osteopathic Doctors Committee that Kalamazoo County osteopathic doctors be invited to become active members. The membership has yet to vote to amend its bylaws before the change can be made.

The Council of the Wayne County Society, on the recommendation of an Ad Hoc Committee, amended its present policy statement on osteopathy by the addition of the following paragraph:

"Doctors of Osteopathy, duly licensed in this State, whose ethical and professional standards meet those provided in the bylaws of the Wayne County Medical Society and who adhere to the principles of Medical Ethics shall be eligible to apply for Active Membership."

LENAWEE DOCTORS ENGAGE IN MANY ACTIVITIES

Several members of the Lenawee County Medical Society (Maurice Galliani, M.D., Donato Sarapo, M.D., Richard Gilmartin, M.D., and Francis Balice, M.D.) assisted in five evening smoking withdrawal clinics Sept. 21-25 in Adrian. Each of the sessions was built around informal discussions by both a physician and a minister, and included audio-visual materials.

In other activities, Lenawee County physicians spent 144 man-hours in local blood banks during 1969 and heard a discussion of new concepts and developments in emergency care medicine by Robert F. Kandel, M.D., chief of the Emergency Division of Henry Ford Hospital, at a recent meeting.

MALPRACTICE TOPIC OF OAKLAND MEETING

"The Malpractice Situation" was the title of a panel discussion presented by members of the Michigan Bar Association at a recent meeting of the Oakland County Medical Society. The discussion included common problems encountered in malpractice defense, information on current remedial legislation proposed in Michigan and a briefing on poorly-understood areas such as implied consent, standards of medical treatment and the physician's responsibility to personnel in the hospital and the operating room.

WAYNE COUNTY POSTS GOLF TOURNEY WINNERS

Ten Wayne County doctors were winners in the annual Wayne County Medical Society Golf Tournament held at the Dearborn Country Club. They were Donald Baltz, M.D., low gross, and Robert McLellan, M.D., low net, Championship Flight; Robert Wyatt, M.D., low gross, and A. W. Boddie, M.D., low net, First Flight; W. D. Hall, M.D., low gross, and H. B. Holloway, M.D., low net, Second Flight; Joseph Ponka, M.D., low gross, and Joseph Eschbach, M.D., low net, Third Flight; Leo Bowers, M.D., Fourth Flight, and James Zurawski, M.D., Interns' and Residents' Flight.

GEORGETOWN U. PROFESSOR ADDRESSES KALAMAZOO PHYSICIANS

Members of the Kalamazoo Academy of Medicine heard Christopher M. Martin, M.D., director of the Laboratory of Clinical Pharmacology, Georgetown University School of Medicine, discuss "The Therapy of Gram-Negative Sepsis: Results of Two Controlled Trials," at their September meeting. Doctor Martin is also director of the Georgetown Medical Division, District of Columbia General Hospital.

GENESEE PHYSICIANS ELECT, INSTALL OFFICERS

New officers of the Genesee County Medical Society were elected at a recent meeting. Anthony Sirna, M.D., last year's president-elect, is now president. New officers include James F. Dooley, M.D., president-elect; Charles A. Thompson, M.D., secretary.

WASHTENAW MEDICAL ASSISTANTS PRAISE COUNTY BULLETIN

The Washtenaw County Medical Society Bulletin was the object of a resolution of appreciation from the Washtenaw County Medical Assistants Society for its good coverage of the medical assistants' activities.

KENT COUNTY SCHEDULES VARIED PROGRAMS

Meetings on medical jurisprudence, nuclear medicine and regional drug information programs are scheduled this month and next by the Kent County Medical Society. The first will feature Ralph F. Woodbury, M.D., of Wayne State University, as speaker, and the second will be presented by Albert E. Heustis, M.D., of Lansing, director of the Michigan Association for Regional Medical Programs.





Consider these three important additions in the expansion and upgrading of your diagnostic and therapeutic patient services — the EK 4 Electrocardiograph, the MW-200 Microwave Diathermy, and the UT/4300 Ultrasound/Stimulator.

Each can play an important role in your practice. All are simple to operate. No need for additional or specially trained personnel. Most important is the availability of wider services for your patients, with fewer referrals. If you already have one of these units, consider the addition of new equipment in keeping with your practice needs.

Call for an equipment check-up,

BURDICK

THE G. A. INGRAM COMPANY
4444 Woodward Avenue, Detroit, Michigan 48201
Telephone: TEmple 2-4444

Muskegon County Medical Society members have been disturbed for some time because of the policies and practices of Michigan Blue Shield, which they believe do not match Blue Shield's claims of performance. The doctors' early expressions of dissatisfaction to Blue Shield were apparently dismissed in the report, "A Commitment Fulfilled," a summary of the first year of Michigan Variable Fee Program, released by Blue Shield in September. The following article is an answer from the Muskegon Society to that report and an announcement of first results of an independent study made by the Muskegon physicians of Blue Shield practices in Muskegon County.

Muskegon Doctors Release Figures of Study Of Their Relationship with Blue Shield

REPORTED BY LELAND E. HOLLY, II, M.D. MUSKEGON

The physicians in Muskegon County had heard so much from Michigan Blue Shield which did not seem to fit the facts of Blue Shield performance as we knew them that we decided to become objective and try to establish whether we were dreaming or not.

To do this we developed a questionnaire. It was exactly what a group of doctors might produce. We are not pollsters or statisticians, but we do think the results of our provincial study are informative.

The 107 active physicians in Muskegon county were given the questionnaires in the spring (61 physicians, or 57 percent, constituting a representative sample, responded in time for tabulation) "to analyze the roles, desires, opinions and experiences of Muskegon County Medical Society physicians regarding third parties in the practice of medicine."

We planned to summarize the findings into a composite to be used to recommend and substantiate actions of the Muskegon County Medical Society as stands on issues of ethical, moral, social and financial significance relative to third-party relationships.

Initially, doctors were to interview doctors, but this did not work out and the county society did not have sufficient funds to hire it done. The tidiness of our study suffered because even though our doctors did their best to answer questions without assistance or urging to fill in all the blanks, there were non sequiturs in responses and not all tallies added up correctly. This is just further evidence of the story like it is.

Complete results of the questionnaires, and the questionnaire itself, are available from the Muskegon County Medical Society, Frank L. Pettinga, M.D., president, and Howard V. Sanden, M.D., secretary.

An important phase of the entire study was an accounts receivable analysis of Blue Shield participation on an aged account and cash amount basis. We knew that 95 percent of us could not answer the question without preparation, so we set up a five-month study beginning April 1.

Twenty-one physicians voluntarily participated in an unusual display of cooperation by opening their accounts for the five months of the study. It is a tribute to the physicians and medical assistants involved that the study could be done so well and their willingness augurs well for further cooperative efforts.

Some of our most interesting findings are summarized here.

Almost 10 percent of the respondents did not know to what extent they participated in Blue Shield. Ten percent said they participated 100 percent. Blue Shield says that 53 percent of Muskegon County M.D.s (87 percent of the D.O.s) participate 100 percent. That appears to us as a significant difference!

Of 43 physicians who reported they participated, at least on a selective basis, 20 stated they simply "wrote off" Blue Shield payments, while 23 did not. Of the 20, fifteen said they would not do that for other insurance companies and one physician quite honestly admitted to having two fee schedules.

The study indicated Muskegon physicians fill out insurance forms under the proper circumstances but the number who charge for this service is surprising. Would there have been a charge five years ago? We think not.

Thirty-seven of 57 physicians responding did not regularly use an itemized MRVS-coded statement. Of these thirty-seven, 23 did itemize and 4 gave total charge only. (There was no response from the balance.)

Calculations from the respondents indicated the number of patients seen by 50 Muskegon physicians in one month was 18,995 of whom only 2,060

TABLE A

Summary Analysis of Delinquent Blue Shield Accounts In 18 Doctors' Participating Cases According to the Month Blue Cross Billed For the Months of April through August, 1969.

	April	%	May	%	June	%	July	%	August	%
Total charges uncollected for 5 month's billings prior to September 1st.	2,174.70	17%	5,632.82	31%	9,888.70	58%	12,701.95	76%	16,894.20	99.8%
Total Blue Shield Billings for Month.	12,523.95		18,455.95		16,925.35		16,554.90		16,931.20	
Age of unpaid acct. (calendar	days)	120-150		90-120		60-90		30-60		0-30

TABLE B

Summary Analysis of Two Aspects of Non-Participation: Group J reports delinquency in patient-doctor payments. Doctor K reports delinquency of Blue Shield-Patient payments.

	April	%	May	%	June	%	July	%	August	%
Non-Participating										
Doctor K	* 130.63		112.50		749.50		477.50		35	
	2,057.50	6%	447.50	25%	1,025.00	73%	727.50	65%	35	0%
Group J	* 2,728.00		779.50		2,689.00		1,396.50		3,856.00	
	6,587.50	77%	1,329.50	59%	3,089.00	87%	1,439.00	97%	3,856.00	100%
Age of unpaid acct. (calendar days)		120-150		90-120		60-90		30-60		0-30

*Amount unpaid Amount billed

received the benefits of physician participation, or l1 percent!

The results of the delinquent account survey are tabulated in Table A. Tables A and B refer to calendar days (not "working days") as the time measure for bill payments since it is the customary and usual measure in the business world. Regardless, it is apparent that we in Muskegon do not enjoy the privileges of Blue Shield's claims of rapid remuneration.

Of 49 responding physicians, 36 reported an increase in their medical practice incomes since 1965. Two reported no change and 11 described a decrease. Of 13 who reported percentage increases,

the average was 21 percent, and of eight who reported decreases, the average was 13 percent. It seems clear to us from our sample that since 1965 our take-home incomes have changed in increments far smaller than some reports would imply.

Forty-one of our respondents were not willing to delegate the right to set their own fees to any individual or group. Fourteen would surrender this right to a committee of doctors. No one was willing to surrender this right to a governmental or insurance company agency. The number 41 appears to be the significant response, but some of us wonder whether it is not really the 14 that that is significant. Is that number 14 on the way up or down?

PLAINWELL SANITARIUM, INC.

Plainwell, Michigan - MU 5-8441

M. Leroy Barry, M.D.

Dan W. Everett, M.D. Wilbur R. King, Ph.D.

The Plainwell Sanitarium is a private psychiatric hospital licensed by the Michigan Department of Mental Health, and member of the American Hospital Association, Michigan Hospital Association, and National Association of Private Psychiatric Hospitals. Our extensive diagnostic treatment services include the following:

- Organic and psychological therapy for the psychiatrically and emotionally disturbed of all ages.
- Diagnostic evaluation of neurological disorders.
- Rehabilitative services for geriatric and convalescent patients.
- Medico-Legal counsel.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for Probate and Juvenile Courts.

There is a real consensus (53 to 1) in the belief Blue Shield should be eased out of its protected and favored position.

Fifty-three of 56 respondents did not believe that Blue Shield is a bulwark against unreasonable governmental interference in our medical practice.

Fifty-seven of 59 respondents believe a free standardized form could be used for all third-party reimbursement whether to the patient or the doctor,

An analysis of multiple responses obtained in the questionnaire indicated there are only three unshakable 100 percent participators among the respondents in our study. To us that is an even more significant figure than the 10 percent complete participation. It does appear there is considerable latent as well as overt disenchantment with Blue Shield among our Muskegon physicians.

From our over-all findings we hazard some comments:

(1) There is a certain amount of indifference among our physicians toward any detailed attempt to discover their beliefs, attitudes and experiences but a 57 percent voluntary response from our doctors to our complex questionnaire is tremendous,

in our opinion, and is related to the topic of the study.

(2) Ignorance and/or the lack of clearly identified personal positions played a large role in the absence of physician response in many areas. This represents a serious hiatus in the complete physician's social armamentarium and is probably the real source for his poor public appearance in certain socio-economic areas and for his susceptibility to glib schemes and poorly conceived activities which hold out promise for fulfilling his needs and ideals. We are easy marks!

Our next move in Muskegon will be further investigation into the new questions and questionable response patterns our current study has turned up. We will also extend our attention to other socio-economic areas.



BRIGHTON HOSPITAL

A non-profit foundation

FOR ALCOHOLISM

Member, Michigan Hospital Association, American Hospital Association

A facility designed to rehabilitate and aid the compulsive drinker in arresting his addiction.

Brighton Hospital meets the standards established by the Michigan State Board of Alcoholism and is recommended by that Board. 12851 East Grand River

One block south of I-96 at Kensington Rd. Exit four miles east of U.S. 23

Brighton, Michigan

ACademy 7-1211

(A 16-m.m. sound color film on Brighton Hospital is available for free loan to qualified groups.)

Specialized Service

PROFESSIONAL

is a high mark of distinction

MEDIGAL PROTECTIVE COMPANY

FORT WAYNE INDIANA

Professional Protection Exclusively since 1899

DETROIT OFFICE: G. A. Triplett, R. K. Wind and J. K. Galloway, Representatives 27200 Lahser Road, Southfield 48075 Telephone: (Area Code 313) Elgin 3-4848 or 444-1439

GRAND RAPIDS OFFICE: G. J. Haworth, Representative 422 Federal Square Building, Grand Rapids 49502 Telephone: 616-454-4477

Established 1924

MERCYWOOD HOSPITAL

4038 Jackson Road

Conducted by Sisters of Mercy Ann Arbor, Michigan

Telephone — 313 663-8571



Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

Accredited by the Joint Commission on Accreditation of Hospitals and the National League of Nursing. A full Blue Cross participating hospital.

Certified for: Medicare and M.A.A. programs

PSYCHIATRIC STAFF

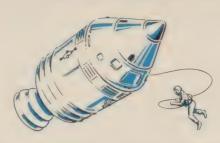
James R. Driver, M.D.

Lyle M. Allis, M.D. Robert J. Bahra, M.D. Dean P. Carron, M.D.

Leonard E. Himler, M.D.* Francis M. Daignault, M.D. Sydney Joseph, M.D. Gordon C. Dieterich, M.D. Jacob J. Miller, M.D.

Rudolf Nobel, M.D. Stuart M. Gould, Jr., M.D. Richard D. Watkins, M.D. Stephen C. Mason, M.D. Philip M. Margolis, M.D. Hubert Miller, M.D.

* 1904 - 1967



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate.

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.



WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals



Appearances may be deceiving



It may be tetracycline but it's not ACHROMYCIN® V Tetracycline HCI unless it bears this signature.



250 mg. and 100 mg. capsules

Contraindications: Hypersensitivity to tetracyclines. Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs. Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Side Effects: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. Kidney—dose-related rise in BUN. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Intracranial—bulging fontanels in young infants. Teeth—yellow-brown staining; enamel hypoplasia. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.



"coughing
is not a harmless
privilege".

Current Therapy 1967, ed. by Conn, H. F., P. 88—

if cough serves no useful purpose

RX Tussionex®

(Resin complexes of Hydrocodone and Phenyltoloxamine)

. it works
(usually
for 10 to 12
hours*)

TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.

Class B narcotic - oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

*DOSAGE: Adults: 1 teaspoonful (5 cc.) or tablet every 8-12 hours. Children: Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N. Y. 14623



GOVERNMENTAL-MEDICAL CARE PROGRAMS

COMPREHENSIVE HEALTH PLANNING

At a recent meeting of the Advisory Council on Comprehensive State Planning a descriptive presentation was made by the Executive Director of the Grand Rapids Area-Wide Comprehensive Health Planning Unit (ACHPU) on the organization and functioning of an area-wide comprehensive planning unit. Herewith are excerpts as informational assistance to members in initiating and organizing an area-wide advisory council in their areas.

Descriptive Information:

ACHPU serves the Counties of Lake, Mecosta, Newaygo, Osceola, Montcalm, Ionia, Ottawa and Kent by operating on a contract basis as an independent subsidiary division of United Fund and Community Services, a coalition type agency.

Twenty-three professional and twenty-nine consumers have representation on the board and selection was made through a nominating committee working through health and other organizations.

Each of the fifty-two members are assigned to one of three sections in service, facilities and manpower which then comprises the Master Planning Committee.

Health Planning Activities:

By using ad hoc committees and other special study groups, ACHPU has been involved in:

Hospital Review Panel: To study acute care facility needs for evaluation of the planning of one aspect of the total community health program. Comprehensive Neighborhood Health Services.

Study Committee: Review of services presently available to the indigent in Kent County.

Analyze Available Data on the Health Condition of the Indigent.

Explore Reasons Why Health Continues a Significant Problem of the Poor.

Formulate a Long-Range Plan for Meeting the Health Needs of the Indigent.

Other ad hoc committee interests are health steering committee — emergency ambulance steering committee; UFCS Rockford area study committee and Council on Alcoholism Evaluation Committee; ECHO Project with Kent County Health Department; Camp physical examinations; health and educational programs for pregnant high school girls; Participation and drafting in writing of model neighborhoods proposal.

Issues and Problems in Area-Wide Comprehensive Health Planning:

Cooperative working relationships in planning within hospitals is lacking.

The planning agency is forced to consider crises planning because of immediacy of problems.

Securing data on area basis is difficult.

A limited supply of trained personnel makes recruiting difficult.

Problem of securing meaningful representation of the poor on the Board.

A need for coordinating data collection efforts and a sharing of information between state and area wide agencies if duplication is to be avoided.

Coordinated efforts needed to achieve cooperation between HEW, OEO, Model Cities, etc. at the national level and similar cooperation between state agencies.

CHP SECTION 314 (c)

Section 314 (c) of the Public Health Service Act supports the following types of activity:

- 1. Full-Time academic training at the graduate level.
- 2. Continuing education for persons involved in health planning and related activities.
- 3. Training for consumer participation in comprehensive health planning.
- 4. Demonstrations.

CHP SECTION 314 (e)

Section 314 (e) of the Public Health Service Act provides for grants "to any public or nonprofit private agency, institution, or organization to cover part of the cost of (1) providing services (including related training) to meet health needs of limited geographic scope or of specialized regional or national significance, or (2) developing and supporting for an initial period new programs of health services (including related training)."

NEW MICHIGAN PROJECT GRANT

Citizens Governing Board of the Detroit Model Neighborhood, 415 Brainard Street, Detroit, Michigan 48201; to provide training for 100 consumer representatives to participate in planning implementation and administration of health programing; Project Director: George Gaines; \$44,270.

(Source: Partnership for Health News, dated August, 1969)

Highest priority will be given to grant applications for the development of projects contributing to the delivery of comprehensive health services. Comprehensive health services have as their focus the needs of individuals and families, rather than particular diseases. The goal of this grant program is the promotion, improvement, and maintenance of the health of a population through the effective use of resources within the community.

A variety of services contributing to a comprehensive health services project are eligible for support under Section 314 (e). These services may vary considerably in scope, depending upon the state of comprehensive health services development in each community. In all instances, however, 314 (e) supported services should promote the development of a comprehensive health services project that provides a continuum of environmental, physical and mental health services necessary for the achievement of the highest level of health.

MENTAL HEALTH

A new, modern facility to provide a full array of services to the mentally retarded will become a reality in Oakland County as a result of a second federal grant to the Oakland County Community Mental Health Service Board. The \$211,562 grant will pay seventy-five percent of the first year's cost of staffing the center. A previous federal grant of \$637,087 announced on July 2, will enable the County to proceed with plans for its construction of the \$1,600,000 building near the County Service Center. The Oakland County Board of Supervisors will match the federal construction fund with a \$1,000,000 appropriation.

This new center will be the first in Michigan using money made available through legislation providing funds to help the retarded with the Center expected to provide continuing day care services for 350 retarded persons and special short-term services for another 500 persons annually. (Source: Oakland County Community Mental

Health Services Board Circular, Vol. 3, No. 4)

NURSING HOMES GET ADDED STATE PAYMENT

An additional \$2.3 million in payment for Medicaid patients in the 1969-1970 fiscal year will be paid to Michigan's nursing home owners.

A reimbursement rate of \$14.48 for patients needing skilled care and \$12.25 for those requiring only basic care will be made.

Previously, nursing home owners received \$14.00 for skilled and \$12.00 for basic care.

A special committee has been studying nursing home operations and the recommendation to increase reimbursements costs will be shared equally by the State and Federal governments. Also recommended is a revision of the payment formula from time to time to allow for cost of living increases. A recent recommendation enacted into law requires each nursing home to disclose its operations costs.

BLUE SHIELD DRUG PROGRAM

"Michigan Blue Shield will add payment for prescription drugs to its prepaid health program for some 1,788,000 members in Michigan October 1, and has responsibility for insuring similar benefits for some 1,170,000 people nationally through local Blue Shield or Blue Cross Plans," Blue Shield President, John C. McCabe said today. All "legend" drugs are covered except contraceptives, and the plan includes injectable insulin. Single prescriptions are limited to a 34-day supply except for certain "maintenance" drugs and prescriptions are refillable at the physician's discretion. The patient "co-pays" a flat sum for each prescription or refill, according to the Blue Shield Pay Plan selected by his group. Co-payment plans range from \$.25 to \$2.00, the amount selected by the automobile groups, and have no connection with different prescription costs. In-Hospital payment of drug costs will not change and will continue to be furnished under regular contract.

(Source: Michigan Blue Shield News, dated September 14, 1969)

CHAMPUS

Civilian Health and Medical Program for the Uniformed Services:

This program provides civilian care to retired members, and the dependents of active, retired, deceased active and deceased retired members of the United States Uniformed Services which includes: Army, Navy, Marine Corp, Air Force, Coast Guard, Commissioned Officers of the Public Health Service and the Commission Corp of the Environmental Science Service and Administration (formally Coast and Geodetic Service).

Persons eligible are:

Spouses and dependent children of active members, retired members, deceased and active and retired members.

Retired Members.

Spouses and children of members of the armed forces of NATO countries assigned for duty in the United States.

All eligibles ten years of age and over will have an appropriate ID card.

One feature of CHAMPUS, use of the non-availability statement, is causing many physicians some confusion. In most cases, the appropriate identification card is sufficient to authorize care. However, spouses and dependent children of active members seeking *inpatient care* and residing with the member must first determine that care is not available in a uniformed services facility.

The brochure provided all physicians by Michigan Medical Service, the fiscal administrator for CHAMPUS for Michigan is quoted:

"A Non-Availability Statement, DD Form 1251, must be obtained for inpatient non-emergency care

if the patient and sponsor are residing in the same area."

Such statements then are not required:

- 1. For out-patient care;
- 2. When the sponsor is residing elsewhere;
- 3. For emergency care, or
- 4. When the sponsor is retired.

MD Placement Notice

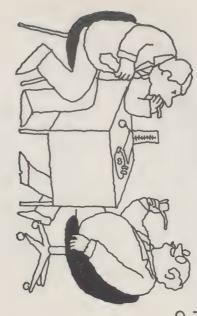
- —Looking for a smaller town that needs and wants a physician?
- —Do you need an associate or assistant in your practice?
- —Are there towns in your area in need of additional physicians?
- —If your answer is YES to any of the above questions, contact

Michigan Health Council John A. Doherty, Executive Secretary 712 Abbott Rd., P.O. Box 431 East Lansing (Phone: 337-1615) (No charge for this service)

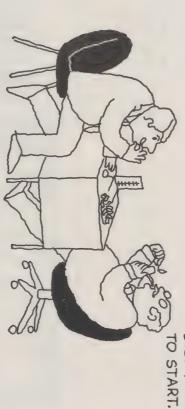
in the treatment of Effectiveness confirmed by another double blind study* 1 SUMMARY Forty cases reported. Cites synergism between androgen and thyroid. No side effects in patients treated. ANDROID **GOOD TO EXCELLENT 75%** 5. Alleviation of fatigue noted 6. Case histories on 4 patients. 7. Although psychotherapy still needed, role of **PLACEBO** 20x chemotherapy cannot be disputed. *"Sexual impotence treatment with methyl testosterone - thyroid (ANDROID) a double blind study" - Montesano, Evangelista: Clinical Medicine, April 1966. also available with ESTROGEN Android-E CONTRAINDICATIONS — Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low. Each Tablet Contains: Each Tablet Contains: Methyl Testosterone 2.5 mg. Ethinyl Estradiol 0.02 mg. Thyroid Ext. (1/5 gr.) 10 mg. Thiamine Hydrochloride 10 mg. Glutamic Acid 50 mg. Choice of 4 strengths Glutamic Acid INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. ODSE: One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. SIDE EFFECTS: In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsuistim, enlarged cilioris. Symptoms can be avoided by keeping the dosage below 300 mg of restosterome per month. CONTRA-INDICATIONS: See Android. Ethinyi estradiol is not to be used in latent malignancy of reproductive organs or mammary glands. Android-HP Android-X Android Android-Plus EXTRA HIGH POTENCY WITH HIGH POTENCY B-COMPLEX AND VITAMIN C Each white tablet contains: HIGH POTENCY Each yellow tablet contains: Each red tablet contains: Each orange tablet contains: Methyl Testosterone 2.5 mg. Methyl Testosterone 5.0 mg. Thyroid Ext. (1/6 gr.) 1.0 mg. Thyroid Ext. (1/2 gr.) 3.0 mg. Glutamic Acid 50 mg. Glutamic Acid 50 mg. Thiamine HCL 10 mg. Thiamine HCL 10 mg. Methyl Testosterone .12.5 mg. Thyroid Ext. (1 gr.) ... 64 mg. Glutamic Acid50 mg. Thiamine HCL10 mg. Methyl Testosterone ... 2.5 mg. Thyroid Ext. (¼ gr.) ... 15 mg. Ascorbic Acid (Vit. C) ... 250 mg. Thiamine HCL 25 mg. Thiamine HCL 25 mg. Glutamic Acid 100 mg. Pyridoxine HCL 5 mg. Niacinamide 75 mg. Calcium Pantothenate 10 mg. Vitamin B-12 2.5 mcg. Dose: 1 tablet 3 times daily. Dose: 1 tablet 3 times daily. Dose: 1 or 2 tablets daily. Available: Bottles of 100, 500, 1000. Available: Bottles of 60, 500. Available: Bottles of 100, 500, 1000. Write for literature and samples: REFER TO Riboflavin THE BROWN PHARMACEUTICAL CO. 2500 W. 6th St., Los Angeles, Calif. 90057 Dose: 2 tablet twice daily. PDR Available: Bottles of 60, 500.

The Apprehensive Hypertensive

WELL, YOU HAVE WHAT WE CALL CUT OUT SMOKING-ALTOGETHER. BUT WE ARE GOING TO HAVE TO DON'T WANT YOU TO WORRY, HIGH BLOOD PRESSURE, NOW I MODERATE HYPERTENSION-FIRST, WE'RE GOING TO HAVE TO CHANGE A FEW LIVING HABITS.



SHOULD DO IT ... 20 POUNDS TO LOSE WEIGHT. THEN WE HAVE LATER ABOUT THIS WE'LL TALK A LITTLE DIET WE'RE GOING



Regroton to lower blood pressure

chlorthalidone 50 mg. reserpine U.S.P. 0.25 mg.

Regroton®: chlorthalidone 50 mg., reserpine U.S.P. 0.25 mg. *Indications*: Hypertension. *Contraindications*: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. *Warning*: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if shadenical transfer and potassium-containing formulations immediately if shadenical statements. and if depression or peptic ulcer occurs. *Use in pregnancy*: Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with the control of the drawn of the control diately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy

other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers. *Precautions:* Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic two weeks prior to elective surgical procedures. In emergency surgery use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue avoid hypotension during surgery, discontinue therapy with this agent dosage of concomitant antihypertensive agents by at least one-half. To

WE'VE GOT TO GET OR TENSE. AND WE'LL PLENTY OF REST AND AND CALM US DOWN. OUR BLOOD PRESSURE THAT MAKE US ANXIOUS TAKE MEDICINE TO LOWER TRY TO AVOID SITUATIONS



and allay anxiety in hypertension

cially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be penia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, convomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especorticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytosusceptible patients. Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation,

gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. Average Dosage: One tablet daily with breakfast. Availability: Pink, single-scored tablets in bottles of 100 and 1000.

For details, please see complete prescribing information.

chlorthalidone reserpine U.S.P. 0.25 mg

50 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502



Michigan Authors

Donald C. Smith, M.D., F.A. P.H.A.; Harold A. Decker, M.D., F.A. P.H.A.; Edward N. Herbert, M.S.S., and Lois K. Rupke, R.N., Ann Arbor, "Medical Needs of Children in Institutions for the Mentally Retarded," page 1376, American Journal of Public Health, August, 1969.

Nahum Z. Medalia, Ph.D., "Citizen Participation and Environmental Health Action: The Case of Air Pollution Control," page 1385, American Journal of Public Health, August, 1969.

M. L. Sorock, M.D., F.A.C.S., H. H. Bloom, D.D.S., and M. P. Owens, M.D., Detroit, Results in the "Immediate Management of Head and Neck Cancer," page 502, Surgery, Gynecology and Obstetrics, September, 1969.

S. Martin Lindenauer, M.D., F.A.C.S., Norman W. Thompson, M.D., F.A.C.S., Richard O. Kraft, M.D., F.A.C.S., and William J. Fry, M.D., F.A.C.S., Ann Arbor, "Late Complications of Traumatic Arteriovenous Fistulas," page 525, Surgery, Obstetrics and Gynecology, September, 1969.

C. J. Eaton, M.D., and Kenneth L. Doil, M.D., Ann Arbor, "Uterine Aspiration in the Management of Incomplete Abortion," page 588, Surgery, Obstetrics and Gynecology, September, 1969.

M. S. Brent, M.D., Detroit, guest editorial in Michigan Hospitals, page 11, July, 1969.

E. S. Gurdjian, M.D., Detroit, Cranial and Intracranial Suppuration, a book, published by Charles C. Thomas Co., Springfield, Ill.

Clemens H. Fitzgerald, M.D., Eloise, "A Double-Blind Comparison of Haliperidol with Perphenazine in Acute Psychiatric Episodes," page 515, Current Therapeutic Research, Clinical and Experimental, August, 1969.

K. R. Magee, M.D., Ann Arbor, review of book, Modern Neurology, page 1531, Journal of the American Medical Association, Sept. 8, 1969.

Wilbur J. Cohen, Dean, School of Education, U-M, Ann Arbor, "Persistent Problems in Medical Care," page 54, Massachusetts Physician, September, 1969.

G. P. Hodge, Ann Arbor, "Perkeo, the Dwarf-Jester of Heidelberg," page 403 The Journal of the American Medical Association, July 21, 1969.

J. W. Conn, M.D., Ann Arbor, "Postural Increase in Renal Vein Renin Activity," a letter, page 417, Journal of the American Medical Association, July 21, 1969.

J. S. Nosanchuk, M.D., Lee Weatherbee, M.D., and G. L. Brody, M.D., Ann Arbor, "Osteogenic Sarcoma," page 2439, Journal of the American Medical Association, June 30, 1969.

Richard Bates, M.D., Lansing, "Medical Treatment of Alcoholism," page 6, Michigan Hospitals, June, 1969.

Roman R. Knoblich, M.D., Flint, "Pulmonary Granulomatosis Caused by Vegetable Particles (so-called Lentil Pulse Pneumonia)," page 380, American Review of Respiratory Diseases, Vol. 99, No. 3.

Roman Knoblich, M.D., and Eugene Kreiner, M.D., Flint, "Bone Marrow Embolism in Multiple Myeloma," page 153, Virchow's Archives ABT. A Path. Anat. 347.

Richard Bates, M.D., Lansing, "I Take A Tough Line with Troubled Youngsters," page 158, Medical Economics, Aug. 18, 1969.

Frederick H. Epstein, M.D., Ann Arbor, "Elevated Blood Sugar," page 1271, Minnesota Medicine, August, 1969.





Each Cough Calmer $^{\text{TM}}$ contains the same active ingredients as a half-teaspoonful of Robitussin-DM $^{\text{SC}}$: Glyceryl quaiacolate, 50 mg.; Dextromethorphan hydrobromide, 7.5 mg. A. H. Robins Company, Richmond, Virginia 23220

A-H-ROBINS

Hoechst is proud to be able to offer nearly 100 years of patient-centered research to "bridge" the sometimes awesome chasms of medicine.



"Life is short and art is long; the crisis is fleeting, experiment risky, decision difficult."

HOECHST PHARMACEUTICAL COMPANY, Cincinnati, Ohio 45229 Division of American Hoechst Corp.



YES, WE WELCOME MALPRACTICE INSURANCE INQUIRIES.

Call Us Collect From Anywhere In Michigan

Area I Wayne,	Limits	Class I	Class II	Class III	Class IV	Class V
Oakland And Genesee Counties	\$100/300,000	\$145.00	\$210.00	\$629.00	\$987.00	\$1,474.00
Area 2 Remainder of State of Michigan	\$100/300,000	\$145.00	\$210.00	\$453.00	\$686.00	\$907.00

Minimum Premium for Premises — \$33.00 (Premises Coverage Required)

Class I — Physicians — No surgery.

Class II — Physicians — Minor surgery or assisting in major surgery on own patients.

Class III — Surgeons — General practitioners who perform major surgery or assist in major surgery on other than own patients.

Class IV — Surgeons — Specialists.

Class V — Surgeons — Specialists — Anesthesiologists, Neurosurgeons, Obstetricians-Gynecologists, Orthopedists, Otolaryngologists.

Interns and Residents Coverage	Area And 2
Interns	\$78.00
Residents (Class 1 & 2)	88.00
Residents (Class 3, 4, & 5)	215.00

BEN P. STRATTON AGENCY, INC.

P. O. Box 547, Lansing, Michigan 48903 Telephone: (517) 484-2578

Doctor, lawyer, merchant, chief...does your professional corporation retirement program require you to be all four?

It shouldn't. It needn't. It doesn't, if you engage Detroit Bank & Trust as corporate trustee. Our trust department has a full staff of specialists to manage your pension and/or profit-sharing plan. We handle the investments, administer the funds, keep the records, file the reports, notify the participants. In short, we take care of your profits while you take care of your patients—and you can depend on us to continue to do so. We've been serving professional people continuously for 120 years, a longevity record unequalled by any other bank in the state. Any time your practice permits, stop in with your attorney and financial advisor to discuss the details. For an appointment, call 222-3961.





when your patients need continuous potassium supplementation...



offer the unique choice of tangy lime, delicious orange

COLVE E

each effervescent tablet contains 2.5 Gm. potassium bicarbonate (25 mEg. elemental potassium), 2.1 Gm. citric acid, and cyclamic acid

sparkling, effervescent

With its two citrus flavors, K-Lyte offers really *special* taste appeal to assure long-term acceptance... patients will take the K-Lyte you prescribe.

Patients like the special convenience of K-Lyte. Each effervescent tablet dissolves quickly and completely in 3 to 4 ounces of cold water. Just two tablets daily provide 50 mEq. of elemental potassium to help prevent or correct potassium deficiency. K-Lyte is absorbed rapidly—and avoids any potential hazards of potassium chloride tablets.

to guide you in prescribing K-Lyte:

Composition: Each tablet contains potassium bicarbonate (2.5 Gm.), citric acid (2.1 Gm.), cyclamic acid, artificial flavor and color. Contraindications: When renal function is impaired, or if the patient has Addison's disease, potassium supplementation should not ordinarily be instituted. Precautions: Should not be used in patients

with low urinary output unless under the supervision of a physician. In established hypokalemia, attention should be directed toward correction of frequently associated hypochloremic alkalosis and other potential electrolyte disturbances. Patients should be directed to dissolve tablet in stated amount of water to assure against gastrointestinal injury associated with the oral ingestion of concentrated potassium salt preparations. Side Effects: While nausea has been reported in an occasional patient, K-Lyte produces no serious side effects when given in recommended doses to patients with normal renal function and urinary output. Potassium intoxication causes listlessness, mental confusion, tingling of the extremities and other symptoms associated with a high concentration of potassium in the serum. Administration and Dosage: K-Lyte effervescent tablets must be dissolved in 3 to 4 ounces of water before taking. Adults: 1 tablet 2 to 4 times daily, depending on the requirements of the patient. Two tablets (50 mEq. of elemental potassium) supply the approximate normal adult daily requirement. How Supplied: Effervescent tablets - boxes of 30 (orange

© 1969 MEAD JOHNSON & COMPANY . EVANSVILLE, INDIANA 47721





NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and the state levels in achieving these goals.

Oshin Bohjalian, M.D., Crittenton Hospital, Detroit 48206

Efrain O. Dickson, M.D., 4021 Hardswood Dr., Orchard Lake 48033

Sadananda C. M. Goud, M.D., 6634 S. Westnedge, Kalamazoo 49001

Leonard W. Lachover, M.D., 20211 Greenfield, Detroit 48235

Arnold L. Leshman, M.D., 14219 W. McNichols Rd., Detroit 48235.

Benito C. Liu, M.D., 60 W. Hancock, Detroit 48201

Donald D. Massé, M.D., 2401 E. Seven Mile Rd., Detroit 48234

George E. Pickett, M.D., 316 City-County Building, Detroit 48226

James R. Ryan, M.D., 3930 E. Eight Mile Rd., Detroit 48234

Michael E. Rollins, M.D., 212 David Whitney Bldg., Detroit 48226

Rassul S. Saber, M.D., 1400 Chrysler Expwy., Detroit 48207

Alan D. Scher, M.D., 18400 Schaefer, Detroit 48235 David F. Simpson, M.D. (Reinstatement), Detroit General Hospital, Detroit 48226

Russell T. Smith, M.D., 197 Washington St., Battle Creek 49017

John Wade, M.D., 17000 W. Eight Mile Rd., Southfield 48075

Fred L. Wedeking, M.D., Health Center-WMU, Kalamazoo 49001

Burton H. Weintraub, M.D., 15121 W. McNichols Rd., Detroit 48235

Asiruddin Ahmad, M.D., 5770 M-15, Clarkston 48016

Michael J. Curtin, M.D., 6355 E. Surrey Rd., Birmingham 48010

Cecil W. Ely, Jr., M.D., 189 Townsend - Suite 200, Birmingham 48011

Roger L. Gonda, M.D., 15901 W. 9 Mile Rd., #110, Southfield 48075

James V. Huebner, M.D., 287 Winry, Rochester 48063

F. S. Kapadia, M.D., 461 W. Huron St., Pontiac Gen. Hosp., Pontiac 48053

John H. Libcke, M.D., Pontiac Gen. Hosp., Pontiac 48053

Robert B. Sklar, M.D., 21701 W. 11 Mile Rd. #2, Southfield 48075

Milton S. Merry, Adm., Armore Hospital, 814 W. Nine Mile Rd., Ferndale 48220

Charles S. Rogers, M.D., 101 W. John St., Bay City 48706

John W. Ison, M.D., 3535 W. 13 Mile Rd., Royal Oak 48072

Leonard S. Gell, M.D., 7587 Conservation Rd., Ada 49301

Donato Cabrera, Jr., M.D., 1520 N. Michigan Ave., Saginaw 48602

P. Miguel A. Granados, M.D., 3601 West 13 Mile Road, Royal Oak 48072

M. Shamsul Haque, M.D., 625 Purdy, Birmingham 48009

Jeffery M. Jennings, M.D., 200 Elm Street, Birmingham 48008

Anthony S. Keller, M.D., 1705 Bedford Square - Apt. 102, Rochester 48063

John F. Lane, M.D., 228 Orchard St., East Lansing 48823

James M. Simpson, M.D., 1310 Wisconsin Ave., Grand Haven 49417

Walter E. Ward, M.D., 3500 N. Logan St., Bureau of Labs., Lansing 48906

Gary E. Wilson, M.D., 909 Woodward Ave. #122, Pontiac 48053

Nikola G. Georgieff, M.D., 221 Eaton Street, Breckenridge 48615

James G. Knaggs, M.D., 500 S. Grand Traverse St., Flint 48503

Ronald Chen, M.D., 511 Copeman Blva., Flint 48503
Earl J. McGarvah, M.D., 410 S. Ballenger Hwy.,

Flint 48504 William J. Roberson, M.D., 3455 Lippincott Blvd.,

Flint 48507

Solomon C. Werch, M.D., 7320 S. State Road, Goodrich 48438

Manulal Lala, M.D., Grace Hospital, Detroit 49201 Jay Bernstein, M.D., 3601 West 13 Mile Road, Royal Oak 48072

Ray D. Gaines, M.D., Wayne County General Hosp., Eloise 48132

James C. Gilliam, Jr., M.D., 3502 Brush Street, Detroit 48202

Ronald G. Hammond, M.D., 15830 Fort Street, Southgate 48192

Wm. W. Hardy, Jr., M.D., Henry Ford Hospital, Detroit 48202



LARRY T. BURCH, M.D., TECUMSEH,

left Michigan Oct. 1 with his father, the Rev. Herbert Burch of Ypsilanti, for a tour of mission hospitals in Africa and India. Doctor Burch plans an evaluation of the medical work that is being done at the various mission hospitals during his two-month stay. He will work for at least two weeks in hospitals in Africa and India.

THOMAS R. BUSARD, M.D., MUSKEGON,

has been named by Republican State Chairman William F. McLaughlin to a task force on Youth for the state party. The task force will conduct public hearings this fall to assemble information to be presented to Gov. William G. Milliken and Republican congressmen and legislators for policy guidance.

PAUL J. CONNOLLY, M.D., DETROIT,

has been elected chief of staff of Harper Hospital, Detroit. He has been associated with the hospital since 1940 and was named chief of surgery in 1967. A. Jackson Day, M.D., has been named vice-chairman of the medical staff of the hospital.

WILLIAM H. HARRISON, M.D., LANSING,

was presented with an award for "outstanding community service" by the Lansing Negro Business and Professional Women at the organization's recent annual Sojourner Truth Awards Luncheon.

H. C. EDDY, M.D., ADRIAN, AND R. D. COAK, M.D., TECUMSEH,

are members of the Lenawee County Medical Society-appointed committee drawing up by-laws for the new Lenawee County Medical Care Facility, scheduled to open in March, 1970. With other committee members, the physicians toured a similar facility in northern Michigan in mid-October.

MAURICE GALLIANI, M.D., ADRIAN,

described anesthesia's contributions to good medical practice to the Lenawee County Medical Assistant Society members at their Sept. 16 meeting. Doctor Galliani is an active advisor to the group from the Lenawee County Medical Society.

DONALD R. McCORVIE, M.D., WILLIAMSTON,

has been re-elected to active membership in the American Academy of General Practice after duly completing 150 hours of accredited postgraduate medical study in the last three years.



Doctor Conn

Jerome Conn, M.D. One of Four Stouffer Prize Winners

Jerome W. Conn, M.D., of Ann Arbor, is one of four medical scientists named to share in the annual \$50,000 Stouffer Prize for their research into the role aldosterone plays in the regulation of the body sodium content.

The award was presented Oct. 17 in Cleveland during ceremonies in conjunction with the annual scientific sessions of the Council for High Blood Pressure Research of the American Heart Association.

The clinical syndrome of primary aldosteronism was first described by Doctor Conn in 1959 and he also discovered its mechanism and cure. Doctor Conn, a Louis Harry Newburgh University professor of internal medicine at the University of Michigan, reported in 1955 that "It is believed that these studies delineate a new clinical syndrome which is designated temporarily as primary aldosteronism. In its fully developed state it is characterized by the presence in the urine of excessive amounts of sodium-retaining corticoid, by severe hypokalemia, hypernatremia, alkalosis and a renal tubular defect in the reabsorption of water. The latter is probably secondary to chronic hypokalemia as reported by Schwartz and Relman. The failure of renal concentrating ability is not corrected by pitressin." (Presidential address: Part II. "Primary Aldosteronism, a new clinical syndrome." J. W. Conn, M.D., J. Lab. Clin. Med. 45, 3-17 1955.)



NEWS BRIEFS

NEWSBRIEFS/Continued

JOHN H. TANTON, M.D., PETOSKEY,

was guest speaker at a recent meeting of the Pigeon River Audubon Club. Doctor Tanton's hobbies include beekeeping and natural history, especially botany.

TWO LANSING PHYSICIANS.

Maurice S. Reizen, M.D., and D. Bonta Hiscoe, M.D., were recently elected second vice president and secretary, respectively of the Capitol Area Comprehensive Health Planning Association. Named to the board of trustees of the organization were more Lansing-area doctors, including Philip Lange, M.D., from Ingham Medical Hospital; Keith Curtis, M.D., of the Eaton County Medical Society; and Scott Swisher, M.D., of Michigan State University.

PETER S. THOMS, M.D., FLINT,

is in Oman, Saudi Arabia, where he will serve as a medical missionary.

VIRGILIO VILLAREAL, M.D., FLINT,

left in September for three months of Vietnam service. He joins 580 United States physicians who have donated their knowledge, skills and time to the Vietnamese and is the third, following John C. Rawling, M.D., and Franklin W. Wade, M.D., from the Genesee Society to make the trip.

WALTER WARD, M.D.,

formerly with the Michigan Department of Public Health in Lansing, is now acting state health officer for Nevada, effective Sept. 1. He is filling in for the state health officer who is taking a year's leave of absence. Doctor Ward is former medical director of the Cutter Laboratories in Berkeley, Calif.

ROBERT WHITE, M.D., ADRIAN,

has moved from a general practice in Adrian to become school physician at Northern Michigan University in Marquette. He took the new position in mid-June.

E. GORDON YUDASHKIN, M.D., LANSING,

heads a new division which combines two former divisions responsible for state hospitals and community mental health under the Michigan Department of Mental Health. Another new division responsible for program development and long range planning is headed by Philip B. Smith, M.D., Lansing, who formerly headed the mental health department's community services division.





A good way to treat patients and save them money.

LEDERCILLIN® VK

Potassium Phenoxymethyl Penicillin

in tablets and a good-tasting, wild cherry liquid.

Tablets: 250 mg

Oral Solution:

125 mg/5 cc-80 cc and 150 cc 250 mg/5 cc-80 cc and 150 cc

Contraindications: Previous hypersensitivity to penicillin.

Warning: Serious, occasionally fatal, anaphylactoid reactions have been reported; more likely with sensitivity to multiple allergens. Some with penicillin hypersensitivity have had severe reactions to cephalosporin; inquire about penicillin, cephalosporin, or other allergies before treatment.

Precautions: Use with caution in those with his-

tories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm or intestinal hypermotility. Occasional patients will not absorb therapeutic oral amounts. In streptococcal infections, treat until organism is eliminated (10 days minimum) and demonstrate elimination by follow-up culture. With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, black hairy tongue. Skin eruptions, urticaria, serum-sickness reactions, laryngeal edema, fever, eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, nephropathy, usually at high parenteral dosage.

Lederle LEDERLE LABORATORIES A Division of American Cyanamid Company, Pearl River, New York

510-9

IN MEMORIAM

Louis L. Barnett, M.D. Pleasant Ridge

Louis L. Barnett, M.D., Detroit-area physician for 48 years, died Sept. 6 at the age of 71 in his home in Pleasant Ridge.

Doctor Barnett, a private practitioner with special attention to ophthalmology, was a graduate of the Wayne State University School of Medicine. He was affiliated with Sinai Hospital, Detroit.

Ernest G. Bellinger, M.D. Lansing

Ernest G. Bellinger, M.D., Lansing physician for 50 years, died Sept. 23 at the age of 94.

Doctor Bellinger, a general practitioner, was a graduate of the Detroit College of Medicine and Surgery and did graduate work at Children's Memorial and Cook County Hospitals in Chicago. He was affiliated with E. W. Sparrow Hospital, Lansing.

Thomas Francis, Jr., M.D. Ann Arbor

Thomas Francis, Jr., M.D., the Ann Arbor epidemiologist who led the nationwide field trial that proved the Salk polio vaccine safe and effective, died Oct. 1 at the age of 68.

Doctor Francis had been chairman of the University of Michigan Department of Epidemiology since 1941. Jonas Salk, M.D., was one of Doctor Francis' most famous students and credits Doctor Francis as being "probably the most important influence in my life."

Doctor Francis pioneered research on polio and influenza. He and Doctor Salk met at New York University, a year after Doctor Francis became a professor of bacteriology there in 1938.

In 1946 Congress awarded Doctor Francis the Medal of Freedom for developing a vaccine against influenza. His research helped avert an epidemic in World War II.

In 1947 Doctor Francis won the Lasker Award from the American Public Health Association for influenza research.

Myron E. Wegman, M.D., dean of the School of Public Health at U-M, said on the physician's death, "Doctor Francis' Department of Epidemiology has become a mecca for public health workers from all over the world and the whole school has benefited from his stature as a scientist, researcher, teacher and counselor."

Doctor Francis was born in Gas City, Ind., in 1900. He received a B.S. degree from Allegheny College and his medical degree from Yale in 1925.

He remained at Yale as an intern, resident and instructor until 1928. For the next 10 years he did research at the Rockefeller Institute and Rockefeller Foundation.

Welcome B. Lewis, M.D. Battle Creek

Welcome B. Lewis, M.D., Battle Creek anesthesiologist for more than 50 years, died Sept. 10 at the age of 86.

Doctor Lewis, a graduate of the University of Illinois Medical School, was connected with the Battle Creek Sanitarium Hospital as a research chemist and anesthetist for 52 years. He was retired in 1959 but remained on call at the general hospitals in Battle Creek until 1964.

He was a member of the American Chemical Society, the American Association for the Advancement of Science and the Michigan State Anesthesiologists.

Douglas B. McDowell, M.D. Tucson, Ariz.

Douglas B. McDowell, M.D., medical director of Wayne County General Hospital before retiring to Arizona in 1965, died Aug. 6 at the age of 61.

Doctor McDowell was a graduate of the New York University School of Medicine and had practiced privately in West Branch 20 years before accepting the Wayne hospital post in 1950. He retired to Tucson in 1965.

He had been affiliated with Tolfree Memorial Hospital in West Branch.

(Continued on Page 1209)

PSYCHIATRISTS

Liberal Fringe Benefits. Salaries determined on individual basis. Henry Ford Hospital invites all candidates interested in a staff psychiatrist position to contact.

> Han Von Brauchitsch, M.D. Chief, Department of Psychiatry Henry Ford Hospital

2799 West Grand Blvd. Detroit, Michigan 48202

now he can cope...

thanks to

BUTISO SODIUM® (SODIUM BUTABARBITAL)

the "daytime sedative" for everyday situational stress

When stress is situational—environmental pressure, worry over illness—the treatment often calls for an anxiety-allaying agent which has a prompt and predictable calming action and is remarkably well tolerated. Butisol Sodium (sodium butabarbital) meets this therapeutic need.

After 30 years of clinical use... still a first choice among many physicians for dependability, safety and economy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to barbiturates.

Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

Warning: May be habit forming.

Usual Adult Dosage: As a daytime sedative, 15 mg. (1/4 gr.) to 30 mg. (1/2 gr.) t.i.d. or q.i.d. Available for daytime sedation: Tablets, 15 mg. (1/4 gr.), 30 mg. (1/4 gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg. (1/4 gr.), 30 mg. (1/2 gr.).

McNEIL

McNeil Laboratories, Inc., Fort Washington, Pa.





lerramyc oxytetracycline)

Fire victim. Examination reveals second degree burn of lower leg. To combat shock, restore circulatory volume and replace protein loss, plasma is administered. Local pressure dressing applied. Limb elevated to limit the flow of lymph. About 36 hours after admission the patient develops an elevated temperature and complains of pain at the site of the lesion. Dressing removed. A suppurating slough area has developed over part of the burn. A swab specimen is taken for culture and the slough area is debrided. Antibacterial treatment is begun with Terramycin I.M. Days later, recovery is progressing, and the laboratory report shows a mixed infection with a predominance of susceptible coliform bacteria, confirming the therapeutic choice. Terramycin therapy is continued until all signs of infection disappear.

Experience has shown that Terramycin offers special advantages in treating bacterial infections complicating burns, when strains of causative organisms are susceptible. Broadspectrum antibacterial coverage. Activity unaffected by penicillinase. Rapidly achieved therapeutic blood levels. Proven

tissue toleration.

Terramycin I.M. is the only preconstituted broadspectrum antibiotic designed specifically for intramuscular use. Requires no refrigeration. Remains stable for at least two years. Available for immediate use in Isoject, a disposable injection unit. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Terramycin I.M. (oxytetracyčline)





Contraindicated: In individuals hypersensitive to any

Contraindicated: In individuals hypersensitive to any of the components of this drug.

Warnings: If renal impairment exists, even usual doses may lead to excessive systemic accumulation and possible liver toxicity. In such patients, lower than usual doses are indicated and for prolonged therapy oxytetracycline serum level determinations may be advisable. advisable

advisable.
Terramycin may form a stable calcium complex in any bone-forming tissue with no serious harmful effects re ported thus far in humans.
Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.
During treatment with tetracyclines, individuals sus

During treatment with tetracyclines, individuals sus ceptible to photodynamic reactions should avoid direct sunlight. Discontinue therapy at first evidence of skin

sunlight. Discontinue therapy at first evidence of skin discomfort.

Note: With oxytetracycline, phototoxicity is not be lieved to occur and photoallergy is very rare.

Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy.

As with all intramuscular preparations, Terramycin Intramuscular Solution should be injected well within the body of a relatively large muscle. Adults: The preferred sites are the upper outer quadrant of the bur-

preferred sites are the upper outer quadrant of the but tock (i.e., gluteus maximus), or the mid-lateral thigh.

Children: It is recommended that intramuscular injections be given preferably in the mid-lateral muscles of the thigh. In infants and small children the periphery of the upper outer quadrant of the gluteal region should be used only when necessary, such as in burn patients, in order to minimize the possibility of damge to the sciatic nerve

age to the sciatic nerve.

The deltoid area should be used only if well developed such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid shirds of the upper arm. As with all intraand mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

muscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel. Increased intracranial pressure with bulging fontanelles has been observed occasionally in infants receiving therapeutic doses of the drug, but such signs and symptoms have disappeared rapidly on cessation of treatment with no sequelae.

Adverse Reactions: Subcutaneous and fat-layer injection may produce mild pain and induration which may be relieved by an ice pack. Very mild gastrointestinal disturbances, not requiring discontinuance of the drug, may occur occasionally. Allergic reactions, including anaphylaxis, rarely have been observed.

Dosage: Adult: The optimal dosage varies, depending on the type and severity of infection. Unless otherwise specified, a dose of 100 mg. every 8 to 12 hours, or a single daily dose of 250 mg. should be adequate for the treatment of most mild or moderately severe infections. In severe infections, 100 mg. every 6 to 8 hours, or 250 mg. every 12 hours may be necessary.

Serum levels obtained by the recommended dosages are comparable to those provided by the oral dosage of 1 to 2 Gm. daily in adults. Antibiotic therapy should be continued for at least 24 to 48 hours after all symptoms and fever have subsided.

In certain diseases specific courses of therapy may be recommended as a general guide. In reimary and second

all symptoms and fever have subsided. In certain diseases specific courses of therapy may be recommended as a general guide. In primary and secondary syphilis for example, the daily administration of 2 Gm. oxytetracycline, orally, in divided doses for two weeks has given good results. In cases of gonococcal infection two intramuscular injections of 250 mg. each, or one intramuscular injection of 250 mg. combined with one gram given orally as a single dose, will usually suffice, but repetition of this therapy will be required in an occasional case.

In the treatment of hemolytic streptococcal infections, therapy should continue for at least 10 days to prevent development of rheumatic fever or glomerulonephritis. In the treatment of staphylococcal infections indicated surgical procedures should be carried out in all cases. Pediatric: A dosage of 3 mg./lb./day in two doses has been found satisfactory in the treatment of most mild

been found satisfactory in the treatment of most mild to moderately severe infections. For more severe infec-tions, higher dosages may be indicated and should be adjusted accordingly.

Terramycin Intramuscular Solution provides maximum absorption and patient toleration with minimal local

Supply: Terramycin (oxytetracycline) Intramuscular Solution: available in single dose, prescored glass ampules containing 100 or 250 mg. oxytetracycline/2 cc., Isoject® syringes containing 100 or 250 mg. oxytetracycline/2 cc. and 10 cc. multiple dose vials containing 50 mg. oxytetracycline/cc.

More detailed professional information available on request.

this ulcer did not heal...until its surface was cleared of dead tissue and debris



FIRST APPLICATION

ELASE Ointment is applied to a deep ulceration of a finger

EIGHTEEN DAYS LATER Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic lissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.



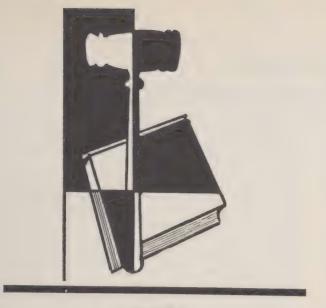
to aid in debridement to facilitate healing in chronic cutaneous ulcers...

Elase Ointment

(fibrinolysin and desoxyribonuclease, combined,[bovine]ointment)

By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation... for healing. Its lytic enzymes effectively break down DNA in dead leuko-cytes and other debris . . . the fibrin in blood clots, serum, and burulent exudates... and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory distur-bances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. Precautions: Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. Adverse Reactions: Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. Discussion: Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated, Available: ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg, thimerosal (mercury derivative); and in 10-Gm, tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg, thimerosal, ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package. Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS



LEGAL

DISCOVERY OF EXPERT WITNESS' IDENTITY GRANTED

(Editor's Note: The following article is quoted from the AMA CITATION newsletter of Sept. 1, 1969, prepared by the AMA Law Department.)

Two physicians should have been granted discovery of the identity of the physician that a patient intended to call as an expert witness in his malpractice suit against them and of the reports, medical treatises, or articles relied on by the witness, a Michigan appellate court ruled. The fact that the patient feared that the physician would not testify if his identity were disclosed was not good cause for denying discovery.

The patient stated that he feared the witness would not testify if his name was disclosed because he could not practice medicine without malpractice insurance and his insurance had once been canceled because he had testified against a physician in a malpractice action.

The patient's fear that the witness would not testify was not good cause for denying discovery. Generally, expert testimony is necessary in order to establish a cause of action for professional negligence. The weight and credibility of the expert's testimony is directly dependent on his qualifications and experience in the field of his testimony. Adequate trial preparation requires an opportunity to investigate the witness' qualifications and experience. An order was entered requiring the patient to disclose the name of his expert witness and permitting the two physicians against whom the suit was brought to depose the witness with respect to his qualifications and experience in the field of his testimony, and as to any facts not available to the two physicians that he may have considered in forming his opinions. - Klabunde v. Stanley, 168 N.W.2d 450 (Mich., March 25, 1969) from Vol. 19, No. 10

Reuben I. Seime, M.D. Grand Rapids

Reuben I. Seime, M.D., Grand Rapids physician for 13 years, died Sept. 2 at the age of 62.

A recently-named fellow of the American College of Radiology, Doctor Seime was affiliated with the department of radiology at St. Mary's Hospital, Grand Rapids. He had previously practiced 13 years in Ypsilanti.

Doctor Seime was a graduate of McGill University School of Medicine, Montreal, and trained in radiology three years at the University of Michigan.

Floyd W. Singer, M.D. Dearborn

Floyd W. Singer, M.D., Dearborn, former director of industrial medicine at the Ford Motor Co. Wixom plant, died Aug. 29 at the age of 58.

Doctor Singer had retired in 1968. He formerly was a member of the staffs of Providence Hospital, Southfield, and Oakwood Hospital, Dearborn. He was graduated from the Loyola University Medical School and was a member of the Abdominal Surgeons Association.



MSMS members may obtain copies of the AMA "Horizons Unlimited" career handbook with an eight-page Michigan insert by writing to MSMS, P.O. Box 152, East Lansing 48823.

Classified Advertising

\$5.00 per insertion of 50 words or less, with an additional 10 cents per word in excess of 50.

- PSYCHIATRIC RESIDENCIES: We offer nothing but excellent psychiatric training in a stimulating, well organized program located in a culturally advantaged community. Approved psychiatric training. Traverse City State Hospital, Michigan Department of Mental Health. Three and five year programs. Salary, 3 year program: \$10,669; \$11,191; \$12,131. Five year program: \$12,152; \$14,031; \$16,328; \$21,994; \$23,093. NIMH-GP stipends available. Located in Michigan's serene, scenic recreation area on Grand Traverse Bay. Contact Dr. Paul E. Kauffman, Director of Training, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.
- PRACTICE OPPORTUNITY Active General practice in progressing community 30 miles north of Detroit. Modern office, fully equipped and staffed. Present gross over \$70,000 in four day week. Will introduce M.D. or D.O. Priced for immediate sale or lease. Reply Box #10, 120 W. Saginaw Street, East Lansing, Michigan.
- IMMEDIATE VACANCIES FOR SPECIALISTS OR G.P.'S in medical department of a large institution for the mentally retarded. Institution includes a large patient residential area, a pediatric building accommodating some 200 children, a 100 bed infirmary, a 200 bed general hospital with medical, surgical and selective surgery wards, an active O.R., well equipped diagnostic facilities; clinical and genetic research laboratories, X-ray Dept., P.T. Dept., etc. Annual Salary ranges from \$20,000 to \$27,000 depending on qualifications. Michigan licensure, or ECFMG for foreign graduates is required. Contact: Isak O. Berker, M.D., Medical Director, Lapeer State Home and Training School, Lapeer, Michigan 48446.
- FOR LEASE: In attractive Medical Building, four offices available for single or combined occupancy (Total 4000 sq. ft.). Will design to suit. Located in fastest growing area in suburban Grand Rapids. Easy access to all parts of the city. Abundant parking. Opportunity to live in lovely metropolitan area close to Michigan's finest fishing, hunting, sailing and skiing. Ready for occupancy in November. Phone: 1-616-363-3822 or 1-616-361-9387.
- DOCTORS! Monroe, Michigan, City of 30,000 County of 100,000. Located Lake Erie near Toledo, Detroit. Excellent schools, community college, 300 beds in two new hospitals. Openings for General, ENT, Urology, Orthopedic Surgery. Contact: R. W. Wilkins, M.D., Secretary Monroe County Medical Society, 118 Cole Road, Monroe, Michigan 48161
- OBSTETRICIAN-GYNECOLOGIST and Internist needed by a seven man group in Northeastern Wisconsin, adjacent to the Upper Peninsula. Full details on this excellent opportunity may be obtained by writing James Boren, M.D., 1510 Main Street, Marinette, Wisconsin 54143.
- OBSTETRICIAN-GYNECOLOGIST to associate with young certified O.B. Brand new hospital. Michigan Thumb recreation area. \$22,000 first year, then full partnership. James M. Mullaney, M.D., 206 N. Heisterman, Bad Axe, Michigan 48413 (517) 269-7409.

- WANTED: General Practitioner for private and industrial practice Suburban Detroit, full or part-time. Terms open. Michigan license required. Reply Box 162, Madison Heights, Michigan 48071.
- WANTED: Younger general surgeon-GP for opening in busy established practice in town of 3500 in N.E. Minn. Salary \$45,000 first year, then partnership. T. C. Leach, M.D., Babbitt Clinic, Babbitt, Minnesota 55706.
- NEW EXPANDING OPPORTUNITIES for family physicians and physicians specializing in pediatrics, general surgery, internal medicine, urology, radiology, anesthesiology; in medically-awakening community. Contemporary, automated, 105-bed, new hospital to be completed in the fall of 1970. Present hospital to be converted into long-term unit. Patient service area 50,000 people. Medical staff leading and supporting recruitment efforts. Excellent community location, forty miles equidistant to Milwaukee or Madison. Complete educational, cultural and recreational facilities. Possibility of new medical office building adjacent to new hospital. Immediate satisfaction in practice, income and family living. Special assistance if needed. Write or call Leo C. Bargielski, Administrator, Watertown Memorial Hospital, 1301 E. Main Street, Watertown, Wisconsin, 53094; telephone (414) 261-4210 for more information.
- INTERNAL MEDICINE practice for sale: will introduce; Florida license required. P.O. Box 4481 Miami Beach, Florida 33141.
- EXTREMELY BUSY two man group needs OB man, who is willing to do some general practice, or a GP who particularly wants to do OB. New modern 80 bed hospital with CCU unit. Small town in northern Michigan, serving an area of about 12,000 people. Office space available, and financial arrangements entirely open to discussion. P.C. possible. Write Box 12, 120 West Saginaw, East Lansing, Michigan 48823, or phone (517) 846-6122.
- MEDICAL TECHNOLOGISTS: Also Histo-technologist ASCP registered or eligible. Modern clinical laboratory. Starting salary \$636 per month with increases to \$760 per month. A shift differential is paid for afternoon and night shifts. Excellent fringe benefits include tuition reimbursement, paid vacations, insurance and holidays. Write or call collect (517) 487-6111 Edward W. Sparrow Hospital, Personnel Department, 1215 E. Michigan Avenue, Lansing, Michigan 48912.
- INTERNIST: Board certified or eligible. 233 bed hospital in Michigan's vacationland. All seasons sports resort area, skiing, hunting, fishing. Licensure any state. Salary based on qualifications. Excellent fringe benefits. Non-discrimination in employment. Contact, Chief of Staff, VA Hospital, Iron Mountain, Michigan 49801.
- GENERAL SURGEON, age 44, board certified, experienced, intends to relocate July 1970. Consider any location in Michigan, solo practice or association. Reply Box 11, 120 West Saginaw Street, East Lansing, Michigan 48823.

Index to Advertisers They Help Make Michigan Medicine Possible

Arch Laboratories1158	Mead Johnson Laboratories1156, 1157,
Brighton Hospital1181	1196, 1197
Bristol Laboratories1146	Medical Protective Co
Brown Pharmaceuticals1189	Merck, Sharp & Dohme1148, 1149, 1150
Burroughs Wellcome & Co1171	Mercywood Hospital1182
Campbell Soup Co	Michigan Medical Service1122
Classified Ads1211	National Drug Co Cover II, 1169, 1170
Detroit Bank & Trust1195	Parke-Davis & Co
Fisher Bldg., The1202	Pfizer Laboratories1206, 1207
Geigy Pharmaceuticals1153, 1174, 1175,	Plainwell Sanitarium1180
1190, 1191	Poythress, Wm. P1183
Henry Ford Hospital1204	Professional Management1211
Hoechst Pharmaceuticals1193	
Hynson, Westcott & DunningCover III	Robins, A.H. & Co 1117, 1192, 1199, 1200
Ingram, G.A., Company1158, 1178	Roche LaboratoriesCover IV, 1172,
Lederle Laboratories1120, 1158, 1184,	
1185, 1203	Searle, G.D. & Co
Lilly, Eli & Co	Strasenburgh Laboratories1186
Mallard, Inc	Stratton, Ben P
McNeil Laboratories	Wyeth Laboratories

Increase Practice Control Through MANAGEMENT By

Modern office and financial management offers realistic methods toward achievement of personal life goals. A logical outcome of PM's services is the attainment of your objectives.

OBJECTIVES

- More Time for Patient
- . More Time for Leisure
- Better Collection Control
- Better Cost Control
- Assistance With Financial Planning
- . Identify Business Problems
- Seek Best Solutions to Problems



PROFESSIONAL MANAGEMENT

Black and Skaggs Associates, Inc. Battle Creek, Michigan

Serving Michigan Physicians

Offices in these cities Ann Arbor - Battle Creek - Berkley - Detroit - Flint Grand Rapids - Lansing - Muskegon - Saginaw - Traverse City

QQNOTES & QUOTES 99

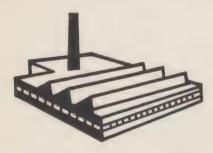
BY HERB AUER, EXECUTIVE EDITOR

"Children in a good sex education program," Frederick J. Margolis, M.D., Kalamazoo, told a State Board of Education hearing in Kalamazoo, "have learned a lot and their value system, their morals, their ethics, their total view of life and their view of other people goes up."

He branded an anti-sex education drive by the John Birch Society as "absolutely fake politics" to scare up society support.

From the September, 1969 issue of *Psychology Today* which is devoted to a consideration of the nature of stress, we quote the following excerpts from an article by Robert L. Kahn, Program Director of the Survey Research Center of the U of Michigan's Institute for Social Research:

"A man's job and his health are closely related. The lower his position, the more likely it is that he is unhealthy. If he is promoted, his health will tend to improve; if he is demoted, he will tend to be-



come ill. The blue-collar worker is more likely to have ulcers than the executive. But even if his job status indicates that his health should be good, conflict and tension within a man's job-role can affect his well-being."

"The great challenge for this generation," says Peter F. Druker, New York University professor of management, "is how to make in-

stitutions perform—not how to tear them down. And therefore our great challenge is how do we make government capable of doing its job—not how do we defend against it."

In his article in a recent issue of Marketing-Communications journal, he reported that young people "are no longer for government." He calls for constructive efforts to please the consumer "or spend the rest of our lives fighting rearguard actions which one can never win and in which one can only lose more and more."

A little boy wrote a letter to God, telling of his family's poverty and asking for \$100 to help out. The letter got to the Postmaster General in Washington. He read it, put \$5 into an envelope, and sent it to the little boy. A week later he got a reply: "Dear God, thanks for the money. But next time, please don't send it through Washington. They took 95 percent."

This little story was carried recently in the National PTA Magazine.

Physicians and their patients utilize the rental goods industry. Which now has an estimated total annual dollar volume of upwards to one billion dollars. One of the growing rental areas related to health care is the rental of invalid rehabilitation equipment. There are an estimated 4,000 independent retail businesses and several major franchisers with 1,000 outlets.

Four suggestions "to meet the nation's crisis in medical education and medical services" are offered in the address given by A. Nicholas Taylor, M.D., when in-

augurated as the eighth president of the Chicago Medical School this summer. He said "we must do one or all of the following:

"1. Reduce the time for preparation of physicians.

- "2. Increase the productivity and efficiency of the physician through increased use of allied health personnel.
- "3. Establishment of new medical schools.
- "4. Expansion of current medical schools."

"The American Medical Association long has viewed itself as the Voice of Medicine. But recent events appear to have speeded a process of dwindling esteem in the



profession and in the public's eyes," so declares the St. Louis Post-Dispatch.

"The public, facing rising medical costs and impatient for broader access to health care, has an immense stake in the AMA's future direction," continues the *Post*.

"The more optimistic profess to see an awakening, if belated, in the AMA to medicine's social responsibilities. They view the AMA's administrative convulsions as a stout effort to reshape the organization so it can cope with the responsibilities," the *Post* adds.

"Hygiene is to keep healthy on the inside while safety is to keep healthy on the outside."

That was one of the statements made by children at Kirkwood, Mo., and collected by their teacher, Harold Dunn. Among the others, reported in a recent article in Minutes, publication of the Nationwide Insurance Company, are the following:

"Scurry is a disease caused by driving too fast."

"Safety is what saves iodine."



Nose clear as a whistle

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

FOR UPPER RESPIRATORY ALLERGIES AND INFECTIONS

Dimetapp Extentabs

Dimetane* (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.

Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy. Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.

Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.

Dosage: 1 Extentab morning and evening. Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY A-H-ROBINS RICHMOND, VA. 23220

sages in section Hasn't Christhich is the skipper had enough excitement ristsallet at Vir-Munrg Stepamina of for one day

For the patient who has been through an accident, the worry and anxiety following the mishap may actually heighten the perception of pain. This is why there's a classic 1/4 grain sedative dose of phenobarbital in Phenaphen with Codeineto take the nervous "edge" off, so the rest of the formula can control the pain more effectively.

A.H. Robins Company, A-H-ROBINS
Richmond, Va. 23220



Owner Breaks Arm When Yacht Runs Aground

Schuyler, Oct. 31. Harry Waters of Covesville incurred a fractured arm acht ck a large rock tially capsized. The fire departm had to rescue Waters by small b Damage to the yacht is estimate

Phenaphen with Codeine

Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (1/4 gr.),16.2 mg. (warning: may be habit forming); Aspirin (21/2 gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, 1/4 gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming).

The compound analgesic that calms instead of caffeinates

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. Contraindications: Hypersensitivity to any of the components. Precautions: As with all phenacetin-containing products excessive or prolonged use should be avoided. Side effects: Side effects are uncommon, although nausea, constipation and drowsiness may occur. Dosage: Phenaphen No. 2 and No. 3-1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.



LACTINEX

to help restore and stabilize the intestinal flora

for fever blisters and canker sores of herpetic origin

Lactinex contains both Lactobacillus acidophilus and L. bulgaricus in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

Lactinex has been shown to be useful in the treatment of gastrointestinal disturbances, and for relieving the painful oral lesions of fever blisters and canker sores of herpetic origin.1,2,3,4,5,6,7,8

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

HYNSON, WESTCOTT & DUNNING, INC.



Baltimore, Maryland 21201

(LX-DS)

References:

(1) Siver, R. H.: CMD, 21:109, September 1954. (2) Frykman, H. H.: Minn. Med., 38:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., 51:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., 15:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., 58:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, 25:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., 20:591-593, November 1965.

Return Postage Guaranteed

MICHIGAN STATE MEDICAL SOCIETY 120 W. Saginaw East Lansing, Michigan 48823



from the discord of anxiety...

IRWIN RICHMAN M D
PA STATE MEDICAL SOC
TAYLOR BYPASS&ERFORD



to emotional harmony

with the aid of antianxiety

Librium® (chlordiazepoxide HCl) 5-mg, 10-mg and 25-mg capsules

In an age of swift change and challenge, susceptible individuals may experience varying degrees of excessive anxiety. The resulting emotional stress may precipitate significant functional disorders or complicate existing organic disease. In properly individualized maintenance dosage, Librium (chlordiazepoxide HCl) quickly helps relieve anxiety and apprehension, provides useful adjunctive therapy in psychophysiologic disorders-yet seldom impairs mental acuity or ability to function. Librium has demonstrated a wide margin of safety in shortand long-term therapy.

Also available:
Libritabs®
(chlordiazepoxide)



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug. Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

NOVEMBER 1969 • VOLUME 68 • NUMBER 22



Federal 'Tax Reform' Proposal Threatens Impact on Professional Service Corporation

BY M. A. RILEY
MSMS LEGISLATIVE COUNSEL

The U. S. Senate Finance Committee has recommended that the "Tax Reform Act of 1969," which has already passed the U.S. House of Representatives, include a provision which would limit Professional Service Corporations formed under state laws to the same allowable dollar maximums of taxfree income to be set aside in a retirement plan as are permitted by the Keogh Act. Under the Keogh law (HR 10), self-employed individuals may defer tax on \$2,500 per year or 10% of earned income, whichever is less, until the retirement of the person (s) covered by the plan in which such funds are invested.

The Michigan State Medical Society and American Medical Association were prominent among those urging the original adoption by Congress of the Keogh Act, designed to bring the self-employed benefits more closely approximating those available to corporate employees.

The Michigan Association of the Professions was similarly active and, in Michigan, also worked closely with the Michigan State Medical Society in securing the passage of the Professional Service Corporation Act of 1962 by the Michigan State Legislature which, pending further improvement of the federal Keogh law, provided

an even more equitable opportunity for professional persons in Michigan to develop adequate retirement programs for themselves and their employees. About one-half of the 1,400 professional corporations established in Michigan have been founded by M.D.s.

The American Medical Association is mounting a vigorous effort to defeat the U. S. Senate Finance Committee recommendation and its constituent state medical societies are requested to lend all possible assistance.

MSMS concurs that since every professional person should have access to equal retirement program opportunity, whether self-employed or not, two facts are clear: first, the states' Professional Service Corporation laws should not be forced into a parity with the federal Keogh Act; and second, the federal Keogh Act itself should be liberalized to substantially raise, or entirely eliminate, arbitrary ceilings.

With the issue presently in doubt as to the fate of the U. S. Senate Finance Committee recommendation, however, physicians presently considering the forming of a Professional Service Corporation would be well advised to postpone any decision until Congress has made up its mind. Professional persons may choose to incorporate for reasons other than those involving pension or retirement program advantages, but the possible

elimination of these should be taken into account and carefully weighed.

MSMS is currently reevaluating the pros and cons of professional incorporation in the event that the Keogh limits are applied. At the same time, all possible support will be mounted in Congress to improve the Keogh Act itself and to oppose imposition of current Keogh provisions upon Professional Service Corporations.

Watch For Maternal Desk Card No. 12

Be sure to read, tear out and file Maternal Health Desk Reference Card No. 12 that will be published in the December issue of Michigan Medicine.

Entitled "The Management of the Non-sensitized Rh Negative Patient," the card has been prepared and sponsored by the MSMS Committee on Maternal and Perinatal Health.

A supplement to Maternal Health Desk Reference Card No. 9, "The Management of the Rh-Sensitized Patient," the latest card is printed on heavy stock designed for handy use in a doctor's files.

Michigan Medical Service Report Shows Medicaid Abuse or Fraud Minimal

Michigan Medical Service has forwarded its full report of the investigation of 81 physicians and osteopaths who received more than \$25,000 each under the Medicaid program in 1968 to the Michigan Department of Social Services—and the report shows that any abuse or fraud is minimal.

Medicaid is doing its intended job in Michigan, John C. McCabe,



Mr. McCabe

president of Michigan Blue Shield, said, and the program is furnishing necessary medical care to those who are eligible at a reasonable cost under regular Blue Shield control and review techniques.

"As a result of our various regular audits and utilization review efforts, as well as from this special study, we conclude that the dollar cost of abuse in the Medicaid Program is minimal," the Blue Shield president said.

THE FULL REPORT of the investigation of 70 physicians and 11 institutions, has been forwarded to R. Bernard Houston, director of the Michigan Department of Social Services, for which Blue Shield administers the program as fiscal agent.

It shows, Mr. McCabe said, that of the total payments of \$5,245,000 paid to the 81 providers, less than one per cent involves possible fraud and relates to three physicians who are now under investigation.

The analyses were conducted under the supervision of Louis F. Hayes, M.D., vice-president of Blue Shield's Medical Affairs Division, who pointed out that audits of 35 of the 70 doctors and all of the 11 institutions had been com-

pleted in normal control procedures before the state requested the list last March.

DOCTOR HAYES REPORT-ED to Mr. Houston that while "irregularities have been discovered, their nature was known to Blue Shield before the list was requested and corrective measures have been and will continue to be taken, many resulting in the recovery of funds."

Blue Shield is questioning some Medicaid payments which relate to: 1. Improper charges; 2. Payment for services not covered by the program; 3. Unsupervised treatments; 4. Payment for services performed by resident physicians and interns ineligible to receive Medicaid monies.

Doctor Hayes, who said that other questionable items involved poor medical record keeping, extensive X-rays, electrocardiograms and laboratory tests, pointed out that \$75,000 of the questionable items have already been recovered.

THE REPORT SAID the Medicaid program was proving to be unexpectedly expensive for various reasons, such as meeting the "vast reservoir of unmet medical needs in a large indigent population," according to Doctor Hayes.

Blue Shield has achieved significant savings in ambulance and pharmaceutical services, a mong others, by negotiation with authorizing agencies, Doctor Hayes added.

Blue Shield has recommended that Sanford Polansky, M.D., Benton Harbor, be given the \$169,000 check he sent back to Blue Shield when his Medicaid income was questioned. Mr. McCabe reports that Blue Shield investigators found that Doctor Polansky's average work day has been 15 hours for at least five years with a patient load of 100 common; that his

practice "did not escalate unnaturally because of Medicaid" and consisted largely of persons previously receiving other forms of public assistance, and that he did perform the services reported and did so at charges (\$5 for an office visit, \$3 for an injection, for example) which were "below average for the state and for like services to private patients."

Excess Medicaid Payments Topic Of Special Meeting

On Oct. 9 Ross V. Taylor, M.D., chairman of The Council; Robert J. Mason, M.D., MSMS president; Kenneth H. Johnson, M.D., MSMS secretary, and Robert E. Rice, M.D., chairman of the MSMS Governmental Medical Care Committee were invited to meet with State Sen. Charles O. Zollar, chairman of the State Appropriations Committee, and other appropriations committee members. The topic: information pertaining to a recently completed inquiry relative to Michigan physicians who rendered in excess of \$25,000 in medical services under the Medicaid program during 1968.

During the course of the meeting, held in the State Capitol Building, Sen. Zollar and the other members of his committee who were present assured the MSMS officers that the release of a list of 82 physicians in Michigan (by names and amounts of Medicaid payments received) to the public press was issued in Washington, D.C., by the United States Senate Finance Committee, and not by the Michigan legislative group headed by Sen. Zollar.

MSMS officials discussed the Medicaid program in detail with the Senate Committee, and full details of the discussion and subsequent developments will be disclosed in the near future.

MDPAC Political Action Workshop Stresses Work of MDPAC, AMPAC

"Membership in MDPAC and AMPAC is basic – to provide the volunteer dollars to do the political education and political action jobs that we must do."

So declared Lee Ann Elliott, AMPAC assistant director, in an address to the MDPAC Political Action Workshop in Lansing, November 8.

The work of MDPAC and AM-PAC was stressed by many speak-

ers, and William Colley, assistant director of the AMA Department of Congressional Relations, described the work of the AMA in Washington. He reported that the AMA for the first time is drafting bills for Congress and having them introduced as AMA-supported legislation. Nine AMA bills have already been introduced in this session, he said.

The excellent addresses were presented not only by representa-

tives from political parties, but also by several Michigan legislators and several MDPAC and AMPAC officials. Senator Lorraine Beebe discussed "Women in Politics" and Senator Coleman Young talked about "The Minorities in Politics." A panel on "The 1970 Issues" featured Representative Robert Waldron, Representative William Ryan, and Senator Thomas F. Schweigert.

Plans for the workshop were developed by Donato F. Sarapo, M.D., MDPAC chairman, and Jack Stack, M.D., Workshop chairman, and a committee.

Doctor Augenstein's Absence Saddens Workshop Members

While physicians and their wives obtained good practical advice from many speakers at the MDPAC Political Action Workshop, Saturday, Nov. 8, there was a sad overtone because one of the scheduled speakers, Leroy Augenstein, did not appear. The search was on during the workshop to find the Augenstein plane that was missing between Richmond, Ind., and his home airport at Charlotte. The plane wreckage and body were found early Saturday evening.

Doctor Augenstein, chairman of the MSU Biophysics Department and member of the State Board of Education, was well known to MSMS leadership and had spoken to many medical groups about social issues. He was the featured "Michigan Foundation for Medical and Health Education Lecturer" at the Michigan Clinical Institute in 1964, talking about "Moral Decisions Facing Medicine Arising from Scientific Advances."

National Orthopaedic Surgeons Pick Aitken

George T. Aitken, M.D., Grand Rapids, was named president-elect of the American Academy of Orthopaedic Surgeons at the recent annual meeting in New York City. S. Benjamin Fowler, Nashville, is president for 1969-70.

Doctor Aitken is medical codirector, Area Child Amputee Center, Grand Rapids, chief of orthopaedic surgery at St. Mary's Hospital, and consultant in orthopedic surgery, Mary Free Bed Guild Children's Hospital and Orthopaedic Center. He became a Fellow of the American Academy of Orthopaedic Surgeons in 1942 and served as chairman of the services section.

Three Physicians Reappointed To State Council

Three physician members of the Comprehensive State Health Planning Advisory Council have been reappointed by Governor Milliken for three-year terms.

Named again were Vernon V. Bass, M.D., Saginaw physician who is vice speaker of the MSMS House of Delegates; Julien Priver, M.D., executive vice president of Sinai Hospital in Detroit, and James Hagans, M.D., member of the Upjohn staff and an associate member of the Kalamazoo Academy of Medicine.

The appointments, made Nov. 6, were for three-year terms.



Sen. Schweigert Petoskey



Among

Workshop

Speakers

Rep. Waldron Grosse Pointe





Rep. Ryan Detroit



Sen. Beebe Dearborn

Doctor Hamburg Elected Chairman of Blue Shield Board

Robert H. Hamburg, M.D., Detroit internist, has been elected



Doctor Hamburg

chairman of the board of directors of Michigan Blue Shield. An assistant professor in internal medicine at Wayne State University's School of Medicine, he is a member of the

MSMS Judicial Commission and House of Delegates and an associate editor of the Detroit Medical News.

Among re-elected Blue Shield officers are Brock E. Brush, M.D., Detroit surgeon, vice chairman, and Robert Stow, M.D., Lansing internist, secretary.

Doctor Hamburg succeeds John M. Wellman, M.D., Lansing, as the Blue Shield chairman.

The election was held at the first meeting of the new Board of Directors. Twelve members of the board were elected at the MSMS Annual Session in Detroit at the annual meeting of the corporation.

Physicians named were James C. Danforth, Jr., M.D., Detroit; A. J. Neerken, M.D., Kalamazoo; Julien Priver, M.D., Detroit; George L. Reno, III, M.D., Detroit, and Charles S. Robers, M.D., Bay City. Paul P. Mitros, D.O., of Drayton Plains, also was elected along with six non-medical representatives.

Wayne Medical Alumni Give \$220,000 To Library

Contributions of Wayne State University medical alumni totaling over \$220,000 toward a new university medical library were presented recently to University President William R. Keast.

A check for the amount was handed over on the steps of the nearly-completed Shiffman Medical Library at WSU by Edward W. Vardon, M.D., Detroit, chairman of the Wayne University Library Fund. Collections for the fund were begun by alumni nearly 20 years ago and the check for \$221,182.17 represented the total collected since then. Another \$25,000 was presented by medical school alumni through the Wayne State Medical Society earlier this year.

"The library was the idea of the medical school alumni," says Doctor Vardon. "National authorities have said that when completed it will be one of the most important medical libraries in the Midwest. The importance of the library and the alumni contributions toward it really can't be overestimated."

Doctor Vardon presented the check to Doctor Keast in the presence of local and university medical officials.



A GIANT CHECK for \$221,-182.87 for the Shiffman Medical Library was presented recently by the Wayne University Medical Library Fund. Accepting the check is William R. Keast, left, Wayne State president; with Don W. McLean, M.D., center, vice chairman of the Fund; and Edward M. Vardon, M.D., chairman of the Fund. The alumni gift completes the financing of the structure.

NEW MSMS DIRECTORY OUT SOON

The new Directory of MSMS Members is at the printers now and will be mailed to all members before December 1.

Members are urged to watch for it and save it for reference purposes.

The names and addresses of the county society membership lists are accurate as of October 1, 1969. The other reference-type lists are accurate as of November 1, 1969.

The 1969 MSMS House of Delegates took formal action that the membership directory should no longer be published each winter, but be issued every other year. Lists of new members and their addresses will be printed regularly in *Michigan Medicine*, and other revised information will be provided there so members may be added to this directory.

The next Directory will be published about December 1971.

Any member finding an error in his name or address is requested to notify the Membership Department, MSMS, 120 West Saginaw, East Lansing, Michigan 48823 so the records can be corrected.

AMEF SCHEDULES FUND-RAISING EVENT NOV. 26

The African Medical Education Fund will hold its annual Thanksgiving eve fund-raising event at the Latin Quarter in Detroit on Wednesday, Nov. 26, from 10 p.m. to 2 a.m.

Since 1960, the AMEF has given financial assistance to 25 African medical students. Fifteen students are receiving financial assistance at this time.

MSMS's Delegation to AMA Prepares Resolutions

The MSMS Delegation to the AMA, in caucus Oct. 29 at MSMS Headquarters, agreed to present the following resolutions before the AMA House of Delegates at its 23rd annual Clinical Convention in Denver Nov. 30 through Dec. 3:

- 1) urging continuing emphasis upon abatement of water pollution by the AMA;
 - 2) urging action on air pollution;
- 3) urging that an overall attack be mounted by the AMA upon the problems of malpractice;
- 4) urging that in any school where no local school health committee exists there should be a physician consultant.

The MSMS delegation also discussed presenting the following resolutions (decisions regarding their introduction will be made at a caucus in Denver just preceding the deadline for introduction of resolutions):

- 1) requesting AMA affirmation of the desire to develop a standardized college physical examination form and stating the desire to create the same;
- 2) supporting the abolishing of contingency fees in malpractice actions;
- 3) requesting the AMA to develop guidelines covering both the training and definition of "assistant physicians;"
- 4) requesting the AMA's Education Council to increase its efforts to bring about bylaws amendments by specialty boards so as to permit doctors of osteopathy to be examined for certification.

Non-Profit Public Corporation Approved to Run Detroit General

Detroit voters Nov. 4 overwhelmingly approved a special proposal to amend the City Charter to permit the mayor and City Council to establish "a nonprofit public corporation" to carry on the administration of Detroit General Hospital.

The final unofficial vote was 282,415 in favor, and 80,288 opposed.

The amendment, according to a statement of Dean Ernest D. Gardner, M.D., of the Wayne State University School of Medicine, will not guarantee a solution to the hospital's administrative ills but "it opens the way to a solution to the many problems at Detroit General." (Detroit General formerly was Receiving Hospital.)

The MSMS Committee to study the Health Problems of the Disadvantaged in the cities at its last meeting heard Dean Gardner and others stress the importance of the charter election as one of the ways to improve the effectiveness of Detroit General.

The minutes of the MSMS Committee report that "there was agreement that the situation at Detroit General Hospital should be studied by MSMS in hopes of resolving problems of the lack of manpower, inadequate facilities, lack of adequate transportation for patients to clinics and hospitals, and the lack of coordinated services. If this situation can be resolved it would, of and by itself, encompass many of the more general problems of providing health care to the poor and disadvantaged."



Jean Pearson, **Detroit News** science editor, received a special citation recently from the Wayne County Medical Society. Offering congratulations are Sidney Chapin, M.D., left, Dearborn, WCMS PR Committee chairman; and James Fryfogel, M.D., right, WCMS president. The award recognized Mrs. Pearson as president of the American Science Writers and for her services to, and interest in, medicine and the medical profession. (WSU Photo)

Judicial Commission Voting Underway

Ballots for the annual selection of physicians to the MSMS Judicial Commission from Districts 1, 4, and 6 were mailed to all MSMS members in the candidate's districts on Nov. 10. The deadline for returning them to MSMS head-quarters for tabulation is Dec. 1.

The Judicial Commission Nominating Committee has submitted the names of the following candidates for election:

District 1 -

Floyd B. Levagood, M.D., Detroit

Clarence S. Livingood, M.D., Detroit

District 4 —

Robert T. Blackhurst, M.D., Midland

Robert F. Powers, M.D., Sagi-

H. Maxwell Golden, M.D., Flint, added by petition

C. Allen Payne, M.D., Grand Rapids

Norbert W. Scholle, M.D., Muskegon

ANNUAL DETROIT TRAUMA MEETING DEC. 3-4

The 17th annual Symposium on Trauma is scheduled Dec. 3 and 4 by the Detroit Regional Committee of the Michigan Committee on Trauma of the American College of Surgeons.

Topic of the two-day meeting at the Wayne County Medical Society Headquarters is "Pitfalls in the Management of Trauma."

Invited guests include Rudolf J. Noer, M.D., professor and chairman, Department of Surgery, the University of Louisville, who will talk about "Memories of Surgery at Detroit General Hospital;" William T. Fitts, Jr., M.D., professor of surgery at the University of Pennsylvania and Robert J. Freeark, M.D., professor of surgery at the University of Illinois.

Doctor Noer will be the featured speaker following a banquet Wednesday evening honoring the Wayne State University Surgery Alumni. General chairman of the symposium is Joseph L. Posch, M.D., F.A.C.S., 1408 Kales Building, 76 W. Adams, Detroit 48226.

DOCTOR MANIACI APPOINTED TO STATE COMMISSION

George Maniaci, M.D., Gladstone, has been appointed by Gov. William Milliken to the State Mental Health Advisory Commission. Maniaci, president of the Michigan Association for Retarded Children, succeeds Richard Johnson, D.V.M., of Kalamazoo, for a term expiring May 8, 1972. Senate confirmation is required.

DOCTOR LESESNE HEADS ALLERGY SOCIETY

John M. Lesesne, M.D., Grosse Pointe, is new president of the Michigan Allergy Society. Other new officers serving with him are Leonard L. DiLella, M.D., Southgate, president-elect; Rudolf E. Wilhelm, M.D., Dearborn, secretary, and Peter P. Barlow, M.D., Birmingham, treasurer.



Remarks from Gov. William Milliken's speech on health manpower given on the opening day of Com-munity Health Week, will appear in the December issue of Michigan Medicine. Disclosing the Governor's ideas and plans for providing Michigan with a much-needed larger health team, the speech was delivered at the 1969 Community Health Week State Conference Oct. 20 at Towsley Center for Continuing Medical Education, The University of Michigan, Ann Arbor. Watch for it in the next issue.

"Formula" Now Seen On Saturday

The "Formula" television program produced weekly by the Michigan Association of the Professions is now being seen over WJIM-TV, Lansing at 6 p.m., Saturday nights. It formerly had a Sunday spot.

The 30-minute, color program, which often deals with medical and health subjects, is moderated by Hugh W. Brenneman, executive director for MSMS and MAP.

DOCTOR GOLDMAN HEADS MSIM

Bernard J. Goldman, M.D., Mount Clemens, was installed as president and L. Dale Shaeffer, M.D., Jackson, was named president-elect at the recent annual meeting of the Michigan Society of Internal Medicine. Doctor Shaeffer will take office in 1970.

U-Michigan Medical Center Board Begins

The new Board of Control of the University of Michigan Medical Center has begun work. The board, which includes representatives from the community for the first time, replaces the former University Hospital Board.

The first formal organization for the Medical Center, the board is composed of three vice presidents of the University, the heads of the three main units of the medical center, a representative of the U-M faculty, three physicians from the medical staff and three members from the community. Chairman is William N. Hubbard, Jr., M.D., director of the Medical Center and dean of the Medical School.

MSMS Study On Doctor-Assistants Interests State

John W. Porter, recently named acting state superintendent of public instruction, attended a MSMS committee meeting in 1967 to discuss the possibile development of assistant p h y s i c i a n educational programs in Michigan. At the time he was in charge of the state's Bureau of Higher Education.

Mr. Porter and other members of the state Department of Education staff have been interested in the ongoing study by MSMS about the feasibility of training assistant physicians in Michigan. One of the state-supported universities is studying possible curriculum, etc., now with MSMS consultation.

Rheumatism Society to Meet

The fall meeting of the Michigan Rheumatism Society is scheduled at 2 p.m. Nov. 29 at Edward W. Sparrow Hospital, Lansing. Guest speaker will be Daniel J. McCarty, Jr., M.D., professor of medicine, University of Chicago, and editor of the publication, Arthritis and Rheumatism.

Michigan doctors are urged to read and study the Nov. 10 issue of the American Medical News, which, in a front page article, reports the AMA presentation on Nov. 3 of its voluntary national health insurance plan — "Medicredit" — to the U.S. House Ways and Means Committee.

Russell B. Roth, M.D., speaker of the AMA House of Delegates, told the committee that the program would not affect the present Medicare program for those 65 and older. It would utilize a system of federal income tax credits to those individuals and families who purchase qualified health coverage from approved private insurance companies or plans.

The following article summarizes MSMS thoughts on

national health insurance.

National Health Insurance Debate Watched By MSMS

The subject of national and compulsory health insurance has been debated again lately by the nation's lawmakers, press and medical leaders.

Evidence of MSMS's views on the subject are found in a resolution passed by the MSMS House of Delegates at its 1969 meeting in Detroit Sept. 28-30 and in Supplement No. 1, titled "National Health Insurance," to the 1969 MSMS annual report, "Where We Stand."

In the November issue of *Michigan Medicine*, Brooker L. Masters, M.D., an MSMS Councilor and chairman of the MSMS Publication Committee, discussed national health insurance in an editorial.

The House of Delegates resolution directs "that The Council of the Michigan State Medical Society take appropriate action to prepare in advance for any system of national health care so that the interests of both patients and physicians can best be served."

The supplement to "Where We Stand" presents statements of support for national health insurance from congressmen, labor leaders, physicians and Michigan legislators.

In an introduction, Ross V. Taylor, M.D., chairman of The Council of MSMS, explains that "In view of the recent endorsement of national health insurance at the Governors' Conference and the mid-October national conference of the Committee for National Health Insurance, several members of the MSMS House of Delegates, some state and county society officers, as well as members of the MSMS Committee on Legal Affairs, requested that material on this subject and Medicine's proposals relating to Health Care Financing be collected, digested and submitted."

The supplement, he continued, "will serve as a convenient resource for all members of the profession as this subject demands further attention by organized medicine."

In a one-page section titled "Medicine's Position?" in the supplement, a section of comments by medical leaders across the nation was preceded with the following:

"There are segments of the population which require financial assistance in meeting their health care needs and the propriety of government funding of this is recognized. But government participation should be limited to financing and not to direct provision of care except where government is recognized to have a direct obligation, i.e., veterans' service-incurred disabilities, Indian Health Service, etc."

NEW U-M COURSE RELATES PHYSICIAN TO SOCIETY

Sixteen hours of classes between November and January are being devoted at the University of Michigan Medical School to a new course relating the role of the physician to social problems. The course, offered in the sophomore year curriculum, was designed and is run by students in this year's junior class.

The course has been divided into three major units: the environment in medicine, the physician's role and responsibility, and possible solutions to problems in medical care today. Five hours are also offered to freshman medical students.

"We felt," explained Larry Corey of Oak Park, one of the students on the planning committee, "that the Medical School has an obligation to teach the social, moral and ethical roles of the physician in society. This was not adequately presented before in the curriculum. So we arranged to present a student-run course dealing with these problems."

U-M MEDICAL ALUMNI HONOR THREE DOCTORS

Three physicians who have given outstanding service to the University of Michigan were presented with Medical Center Alumni Society Awards Sept. 26 at the Alumni Society's annual luncheon. They are John C. Bugher, M.D.; Carl E. Badgley, M.D., and Reed M. Nesbit, M.D.

Doctor Bugher is director of the Puerto Rico Nuclear Center; Doctor Badgley spent more than 50 years at the University before retiring in 1964 and was head of the orthopedic surgery section, and Doctor Nesbit was head of urologic surgery at U-M for 37 years.

Reaction Recorded from Many Sides To Assignment of DO School to MSU

The Michigan State University Board of Trustees is still pondering its acceptance or refusal of the recent decision by the state Board of Education to name MSU as the site for a state-supported college of osteopathy.

The action by the State Board of Education on Oct. 29 was made



in compliance with a bill passed by the Michigan Legislature and signed by the governor to establish a state-supported osteopathic school on

an existing campus of a university with a medical school. The State Board and its staff had extensive discussions with MSU and the medical school officials at both the University of Michigan and Wayne State University.

The MSU Board of Trustees made public a position paper on Sept. 19 that spelled out the arrangements and conditions which MSU considered pertinent in respect to osteopathic education.

The MSU Board of Trustees and university officials are exploring the matter now with the State Board and the osteopathic profession. One of the September conditions set forth by MSU was "full cooperation of the osteopathic profession including cancellation or assignment to MSU of the private college charter of the Michigan College of Osteopathic Medicine and assignment of its assets and liabilities to MSU."

The late Leroy G. Augenstein, member of the State Board of Education and chairman of the MSU Biophysics Department, did not vote in the 5-0 vote to assign the osteopathic school to MSU. He explained that he was in favor of the osteopathic school at MSU but feared that inadequate funds may lead to competition with existing medical schools.

MSU Board Chairman Donald Stevens has declared, "MSU is a pioneer in this area as it is in many areas. We can now establish a College of Osteopathy along with the College of Human Medicine, but we want to make sure we will have enough money to operate both schools."

The future use of the present osteopathic school near Pontiac has been one of the issues as the State Board of Education and MSU confer with the osteopathic leadership. The dean at the Pontiac school, Myron S. Magen, has declared that the Pontiac site should be used "possibly as a health care facility" to train nurs-

ing aides or paramedical personnel.

Before the State Board assigned the DO College to MSU, the osteopaths were reported by the *Detroit News* to be "cautious, but leaning to the MSU affiliation." The *News* quoted Dean Magen of the osteopathic college at Pontiac as saying, "There are some points which we believe require clarification, but we further believe that this can be developed only through direct negotiations between the representatives of MSU and MCOM."

Doctor Sarapo New Member Of State Board

Donato Sarapo, M.D., Adrian, has been appointed by Gov. Wil-



the State Board of Registration in Medicine, succeeding Bradley M. Harris, M.D., of Ypsilanti, for a term expiring Sept. 30, 1973.

liam Milliken to

Doctor Sarapo

Reappointed to the medical

board for similar terms were Frederick W. Van Duyne, M.D., Flint; Howard H. McNeill, M.D., Bloomfield Hills; John J. Coury, M.D., Port Huron, and H. Clay Tellman, M.D., Muskegon.

Michigan Medicine

MICHIGAN STATE MEDICAL SOCIETY

Published semi-monthly, Trimonthly in November and December; 26 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, \$9.00. Printed in USA. All communications should be addressed to the Publications Communications should be addressed to the Publications Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. (**) 1969 Michigan State Medical Society. Phone: Area Code 517, 337-1351.

Second Class Postage Paid at East Lansing, Mich. and at additional mailing offices.

NATE LIBRARY OF MED HOUD WISCONSIN AVE HE PH-SDA MD

2001+

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michiga Medicine

December, 1969 • Volume 68 • Number 24



TIME TO STUDY PRESSING SOCIAL ISSUES

President Mason calls for clarification of thinking

NEW FRA FOR WSU SCHOOL OF MEDICINE

Describes "flavor of revolution in medical education"

GOVERNOR OUTLINES STEPS TO ATTACK HEALTH PROBLEMS

Milliken discusses six activities underway now

PLEDGES GREATER COOPERATION IN SEX EDUCATION

Speakers at MSMS workshop favor state guidelines



YES, WE WELCOME MALPRACTICE INSURANCE INQUIRIES.

Call Us Collect From Anywhere In Michigan

Area I Wayne,	Limits	Class I	Class II	Class III	Class IV	Class V
Oakland And Genesee Counties	\$100/300,000	\$145.00	\$210.00	\$629.00	\$987.00	\$1,474.00
Area 2 Remainder of State of Michigan	\$100/300,000	\$145.00	\$210.00	\$453.00	\$686.00	\$907.00

Minimum Premium for Premises — \$33.00 (Premises Coverage Required)

Class I — Physicians — No surgery.

Class II — Physicians — Minor surgery or assisting in major surgery on own patients.

Class III — Surgeons — General practitioners who perform major surgery or assist in major surgery on other than own patients.

Class IV — Surgeons — Specialists.

Class V — Surgeons — Specialists — Anesthesiologists, Neurosurgeons, Obstetricians-Gynecologists, Orthopedists, Otolaryngologists.

Interns and Residents Coverage	Area I And 2
Interns	\$78.00
Residents (Class 1 & 2)	88.00
Residents (Class 3, 4, & 5)	215.00

BEN P. STRATTON AGENCY, INC.

P.O. Box 547 Lansing, Michigan 48903 (517) 484-2578 Suite 209 19400 W. Ten Mile Road Southfield, Michigan 48075 (313) 357-5083 (313) 357-5085 MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

December 1969 • Volume 68 • Number 24

MARMP Inserts Annual Report, Pages 1261 to 1264

MSMS States Position on Medicaid Program Cost and Quality Control

BY M. A. RILEY
MSMS LEGISLATIVE COUNSEL

MSMS officials met with a state legislative committee chaired by Sen. Charles O. Zollar, at the Senator's request, on October 16 to receive information pertaining to the inquiry regarding Michigan physicians who rendered more than \$25,000 in Medicaid medical services during 1968. The legislative group requested that MSMS review material to be provided to it and then express its views thereon by not later than mid-November. Ross V. Taylor, M.D., Chairman of The Council, MSMS informed Sen. Zollar on November 13 that "subsequent to the meeting with you and members of your committee on October 16, the Michigan State Medical Society received from you on October 27, the four-page double-spaced summary of 11 separate areas in which the Michigan Auditor General found practices under the Medicaid program deemed 'questionable.' These have been reviewed and several of them clearly require technical and medical judgments in the determination of the appropriateness of the care rendered."

Doctor Taylor continued, "It was disappointing to learn at the meeting that the Senate Committee had not reviewed any of these problems with the fiscal agent, Michigan Medical Service. Michigan Medical Service had previously reviewed problem areas with The Council of the Michigan State Medical Society and much of this information was known to them and under study.

"You have requested the Michigan State Medical Society study to make recommendations based upon the material provided us. Obviously, some of the eleven practices listed are impossible to accurately evaluate in the absence of specific facts relating to individual patients and actual diagnoses. Just as obviously, the Society cannot and

would not condone billings for services not rendered, as was alleged by some patients when the Auditor General's investigators interviewed them. Since you have requested a response within thirty days of the October 16 meeting, the Society is responding to you now."

Doctor Taylor told Sen. Zollar, "The Society recommends that any proven case of fraud in connection with Medicaid should be prosecuted through mechanisms already available to the State government and the fiscal agent. The analysis systems developed by Michigan Medical Service and the physicians, presently in existence are capable of disclosing any fraud that may exist.

"The Society concurs that records should be kept by every physician of every medical service, Medicaid or otherwise. This is accepted medical practice and the physician, as well as the patient (and auditor) is not only served but protected by a record setting forth the complaint of the patient, findings and treatment in the case of each service rendered.

"The Society recommends," he went on, "that all suspected problems of utilization control concerning its members should be referred in writing to the fiscal agent. There long have been mech-

(Continued on Page 1224)



Doctor Taylor

U.S. Senate Debating New Rules For Taxing Professional Corporations

BY JUDITH MARR MANAGING EDITOR

Final U.S. Senate action is scheduled to come this month on an important Senate Finance Committee recommendation regarding taxation of professional corporations.

The Finance Committee recommendation is in the form of a provision attached to the Tax Reform Act of 1969 (H.R. 13270) already passed by the U.S. House of

MSU Board Still Pondering DO School Move

The Michigan State University Board of Trustees is still weighing the decision of whether or not to accept the assignment of a statesupported college of osteopathy to MSU.

The affiliation is not effective until it has been accepted by the Board, which has until January 1, 1970, to do so. If the board accepts the affiliation, it will mean that for the first time osteopathy is to be taught as a university discipline and at a public institution.

On October 29, the State Board of Education announced its decision to assign the DO school to MSU. A lengthy story detailing the reaction to the assignment appeared in the November News Extra of Michigan Medicine.

GRAND RAPIDS MAN SUCCEEDS DOCTOR HISCOE AS HEALTH PLANNING HEAD

William J. Downer, Jr. of Grand Rapids has been named chairman of the Health Planning Council of Michigan, succeeding D. Bonta Hiscoe, M.D., Lansing. Mr. Downer is associate administrator of Blodgett Memorial Hospital in Grand Rapids and has served as first vice chairman of the Council for the past year.

Representatives. The provision would limit professional service corporations formed under state laws to the same allowable dollar maximums of tax-free income to be set aside in a retirement plan as are permitted by the Keogh Act for a self-employed individual.

Under the Keogh Act, (H.R. 10), self-employed individuals may defer tax on \$2,500 per year or 10% of earned income, whichever is less, until the retirement of the person (s) covered by the plan in which such funds are invested.

The American Medical Association's Washington, D.C. staff has been actively campaigning in the Senate to defeat the Finance Committee recommendation. Commitments have been obtained to strongly represent the cause of tax equalization for professional service corporations.

Ted Chilcoat and James W. Foristal of the AMA Washington staff reported that the schedule for Senate discussion of the recommendation called for the Finance Committee's reporting out a bill prior to Thanksgiving, with debate to start immediately. Floor amendments were expected after Thanksgiving with final Senate action to come prior to Dec. 10.

At the time this article went to press, however, the Senate was still deliberating the many amendments proposed to the Tax Reform Act, among them the Finance Committee's recommendation on taxation of professional corporations.

The AMA has been joined by its state societies and the American Association of the Professions, with its component organizations, in the fight against the Finance Committee recommendation.

MSMS concurred that since every professional person should have access to equal retirement program opportunity, whether self-employed or not, two facts are clear: first, the states' Professional Service Corporation laws should not be forced into a parity with the federal Keogh Act, and second, the federal Keogh Act itself should be liberalized to substantially raise, or entirely eliminate, arbitrary ceilings.

(Related provisions of the Tax Reform Act of 1969 being considered by the U.S. Senate, support the controversial IRS regulation which declared that income derived by a tax-exempt organization from selling advertising in its journal constitutes unrelated business income and is subject to taxation. The AMA, according to Joe D. Miller, Public Affairs Division director, is contesting this provision on the grounds that it represents tax discrimination, there has been no opportunity for a hearing and there should be a complete review of all pension programs for the purposes of tax deductions.)

The AMA and MSMS have advised physicians to hold off on the decision to incorporate until Congress has made up its mind. Persons might choose to incorporate for reasons other than those involving pension or retirement program advantages, but the possible elimination of these should be taken into account and carefully weighed.

The issue is involved and confusing. Thus, as a service to Michigan physicians, MSMS plans a complete resume of recent federal action on the subject of professional corporations, to be carried soon in *Michigan Medicine*.

By presenting in the article the chronological order of rulings on professional incorporation as well as a representation of viewpoints on the advantages and disadvantages of incorporation, MSMS hopes to help the Michigan physician be better able to decide whether or not to incorporate,

Watch for the lengthy and detailed article in the January issue.

Blue Shield Rate Hike Request Okayed

The Michigan Insurance Commission has approved Michigan Blue Shield's request for a 16.7 per cent rate hike for variable fee health insurance. The rate increase will go into effect Jan. I and continue in effect until April I, when additional increases might be allowed.

Monthly insurance rates will increase from about \$11.87 to \$14.51 for the cheapest plan and from \$13.87 to \$17.06 for the top plan. The Blue Shield M-75 plan for elderly persons was not included in the petition for rate hikes and those rates are not to be increased now.

The Michigan increase was the first since 1965, and is due, according to Claud McCann, commission director for health service plans, to a marked rise in doctors' fees since 1965. Fee increases had been averaging 2.8 per cent from 1960 through 1965 but in the years 1966 through 1968, rose 5.8 per cent, 7.1 per cent and 5.6 per cent, respectively.

Suicide Center Answers 3,454 Calls in First Year

During the first year of the Detroit Suicide Prevention Center's existence, 2,446 suicide-related calls were received, according to Bruce L. Danto, M.D., Detroit, director. Phone calls to the center during the year totaled 3,454, with the difference representing people with other kinds of trouble.

Of the 2,446 suicide-related calls, 309 hung up before completing their calls, according to Doctor Danto. Of those the center talked with, 1,600 were referred to helping agencies. The center followed through with all of these and Doctor Danto reports many have been helped by the service.

The center has 92 active volunteers manning its 24-hour phone contact service.

FOUR PHYSICIANS HONORED DURING 1969 HEALTH WEEK

(See related articles and stories elsewhere in this issue.)

Several Michigan doctors were among those who received special awards during ceremonies in Ann Arbor and Detroit marking the recent Community Health Week.

The awards were presented by MSMS, the Michigan Health Council and the Michigan Association of the Professions, sponsors of the Michigan Community Health Week observance, to:

Lionel F. Swan, M.D., Detroit, for his outstanding efforts in Detroit and throughout the United States as president of the National Medical Foundation in recruiting black students for medical and allied health professions;

Milton Palmer, M.D., Detroit, and Mrs. Palmer, for their efforts in promoting health careers in their communities through inaugurating a Medical Careers Club program in inner-city schools that has received national acclaim;

Sidney E. Chapin, M.D., Dearborn, an MHC past-president, who represents the Council on the Michigan Commission on Aging, for his outstanding efforts in improving community health programs throughout Michigan, and particularly for his efforts with the senior citizens of Michigan, and

the late Albert C. Furstenberg, M.D., Ann Arbor, former dean of the University of Michigan School of Medicine, who was named to the Michigan Health Council's Hall of Fame in Health.

DOCTOR HENDERSON NAMED TO NATIONAL BOARD

A Michigan physician, John W. Henderson, M.D., of Ann Arbor, has been elected to the board of the National Society for the Prevention of Blindness, Inc. Doctor Henderson is professor of ophthalmology at the University of Michigan Medical Center.

Michigan Needs 2,000 Physicians, MHC Estimates

Staggering totals of approximately 600 family physicians and 1,400 medical specialists are needed currently to serve Michigan communities, reports John A. Doherty, executive director of the Michigan Health Council.

Nearly 200 Michigan towns with populations in excess of 1,000 are looking for family doctors and medical specialists. Approximately 50 of the state's communities of under 1,000 population are without any physician at all, adds Mr. Doherty.

Some communities need only one doctor while other communities need a great many, he continues. For instance, a deficit of over 70 doctors of medicine, representing 13 different medical specialties and 20 additional family doctors, was revealed by a recent survey made by Lansing physicians.

Among the most critical are the towns of Deckerville and Millington and the permanent settlement on Mackinac Island.

Deckerville's only physician for its 1,000 residents and 7,000 population in the surrounding "thumb area" recently sold his practice and moved to Florida, his health nearly ruined from his arduous schedule. Millington has one physician who has between 85 and 125 patients seeing him daily.

And the 600 year-round residents on Mackinac Island, without any physician since September, are especially worried with the coming of near-isolation during the winter months.

In the hopes of attracting interested physicians to fill the vacancies, *Michigan Medicine* will publish in the January issue a complete list of the towns needing physicians.

MSMS States Position on Medicaid Inquiry

(Concluded from Page 1221)

anisms for peer review available to the Michigan Medical Service which serves as fiscal agent."

MSMS will issue a statement with respect to the peer review mechanisms which also involve its component societies. This statement will be given the widest possible dissemination and will make it very clear that any individual citizen may refer matters of complaint regarding MSMS members to either the local or state organization. The statement will clarify how this may be done.

"You are undoubtedly aware," Doctor Taylor reminded Sen. Zollar, "of the recent 'White House Report on Health Needs' which stated that a Task Force has been established by the Secretary of Health, Education and Welfare under the leadership of Under Secretary Veneman, charged with a number of specific responsibilities foremost of which is the development and recommendation of Medicaid utilization review procedures. The purpose of this activity is to assure that the government gets true value received for its health dollar.

"The Society is also committeed to assist in developing the best system in which consumers of medical care can receive quality services at a reasonable price," said Doctor Taylor. "The medical profession recognizes responsibility to cooperate with both the government and private prepay health insurance carriers in the development of constructive policies for the delivering and pricing

of services. MSMS pledges cooperation with the Department of Social Services and Michigan Medical Service in Michigan. The recommendations of the national Task Force should be of great value to you in the development of guidelines for use within the State of Michigan.

"Meanwhile, you should know that the peer review systems of the Society, which far predate the passage of the Medicaid (and Medicare) programs, have been expanded greatly in recent years. Through the establishment of a State-level Judicial Commission in 1965, and the expansion of Regional Advisory Committees to cover the entire State in 1967, MSMS has improved the methods to engage in meaningful and effective utilization review involving its members. MSMS invites use of this system by the fiscal agent concerning members of the Society, asking only that there be requests or notification with appropriate documentation of problems so that prompt and appropriate study and evaluation can be undertaken.

"The Society thanks you for the opportunity to discuss with you this subject of great importance. Continuing discussion of mutual problems will be of great value and MSMS will offer any additional assistance within its capabilities. As you previously stated, there are often judgments to be made which can only be made by physicians. The mechanisms for obtaining these judgments already exist and should be used more fully whenever such professional judgments are necessary and involve members of MSMS."

Doctor Tanner Of Detroit Receives Double Honors

Natalia Tanner, M.D., Detroit pediatrician, has been singled out for two honors recently.

Doctor Tanner was named to the National Academy of Pediatricians Committee on Youth for a three-year term and was named chairman of the pediatrics section of the National Medical Association.

Doctor Tanner is assistant pediatrician at Children's Hospital of Michigan, Detroit; instructor in the department of pediatrics, Wayne State University; pediatrics consultant to the Crittenton General Hospital maternal and infant child care project and chairman, Child Health Committee of the Wayne County Medical Society.

The Maternal Health Desk Reference Card No. 12, a valuable addition to any physician's scientific files, is included in this issue of MICHIGAN MEDICINE. Printed on pages 1303-1304, the subject of the card is the "Management of the Non-sensitized Rh Negative Patient."

Sponsored and prepared by the MSMS Committee on Maternal and Perinatal Health, the card is a supplement to Maternal Health Card No. 9, "The Management of the Rh-sensitized Patient." It is printed on heavy card stock and designed to fit easily in a doctor's files. Be sure to tear it out and save it.

New WSU Ophthalmology Chairman Announced

Robert S. Jampel, M.D., of the Institute of Ophthalmology at Columbia Presbyterian Medical Center, will take over July 1 as chairman of the Department of Ophthalmology at the Wayne State University School of Medicine and director of the Kresge Eye Institute of Wayne State University.

Announcement of his appointment was made recently by Ernest Gardner, M.D., dean of the WSU School of Medicine. Doctor Jampel, who is an assistant professor at Columbia University, will succeed Albert D. Ruedemann, Sr., M.D., who is retiring after 21 years as WSU's Chairman of Ophthalmology.



ROBERT J. MASON, M.D. PRESIDENT, 1969-70

Now is Time to Study Pressing Social Issues

(Note: Following are some excerpts from the address given by Doctor Mason to the 1969 MSMS House of Delegates)

In the field of social legislation, it is important for physicians to constantly review in broad, general lines many of the social problems that will be confronting our profession. MSMS has been in the vanguard of so many progressive ideas and Michigan Medicine has attained many firsts throughout the nation because of our programs and activities.

We should be considering especially those social problems that medicine can affect. We should have a plan to present at the appropriate time before



some governmental agency forces emergency medical decisions upon us.

Organized medicine should be giving considerable thought to the medical aspects of the sterilization of the unfit (those whom we know from our medical information will produce unfit offspring) and the protection of society in general against a population explosion. These areas will take extensive philosophical elaboration to evolve a clear-cut medical program, but the time is coming when these problems will need to be met with straightforward thinking.

Another social problem that we need to more clearly define and to give unemotional thought to is the question of abortion — and the various ramifications of it.

We should begin to clarify our medical thinking on the social problems that we are facing in regard to the rights of individuals who are incurable and who have the inalienable right to die with dignity. This presents a whole host of medical opinions and evaluations that need to be clarified. We should be prepared to present a humane and sound medical opinion as to the rights of the incurable patients today.

These are social situations that we cannot sweep under the rug and forget they exist. They are paramount today and will continue to be festering problems. We must give clear thinking to the solutions of these medical-social challenges.

It is extremely important that we, as physicians, identify ourselves with social issues at city, county, state, and national levels, so that the united voice of medicine can be heard. In this way our ideas and understanding and thoughts will be made known in all councils that have to do with medicine and the care of our patients. We must stand four-square on the heritage handed to us from our predecessors and live up to the true capabilities of our birthright.

In addition to practicing the best medicine we are capable of, we must deal with the social issues facing us as citizens and as physicians. It is important that we re-evaluate our lives, our thinking and our activity.

Only by markedly extending our hands and brains under the leadership of our profession can there be hope of serving the public even more effectively.



To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracy-cline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Castrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given I hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

LEDERLE LABORATORIES

A Division of American Cyanamid Company, Pearl River, New York

INFORMATION

FOR CONTRIBUTORS

- 1. Address scientific manuscripts to the Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.
- 2. Submit original, double-spaced typewritten copy and two carbon copies or photo copies on letter size $(8\frac{1}{2} \times 11 \text{ inch})$ paper.
- 3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.
- 4. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide a latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.
- 5. Illustrations should be submitted in the form of glossy prints or original sketches from which cuts, or plates, will be made by Michigan Medicine. Michigan Medicine will pay the first \$25 of the engraving bill, and the authors shall pay the balance. An estimate of the cost will be submitted to authors before cuts are ordered.
- 6. References will ordinarily be limited to seven in number. Exceptions may occasionally be made.
- 7. Contributors will be notified as soon as practical if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.
- 8. Articles should ordinarily be less than four printed pages in length (3000 words).
- 9. References should conform to Cumulative Index Medicus, including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.
- 10. Specify address to which galley proofs should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.
- 11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.
- 12. It is understood that material is submitted for exclusive publication in Michigan Medicine.

Michigan Medicine

IN THIS ISSUE

SCIENTIFIC ARTICLES

- 1231 A New Era for Wayne State University School of Medicine; Joseph W. Hess, M.D.
- 1235 Sudden Deafness; Burton F. Jaffe, M.D.
- 1239 Laboratory Animal Science and Biomedical Research; Warren G.
- 1243 Blood Glucose and Drug Levels in Normal Fasting Subjects Following Single Oral Doses of Tolazamide and Chlorpropamide; Ervin Novak, M.D., Keith Borden, M.D., Trieste Vitti, Ph.D., and Martha Hearron, M.S.
- 1247 Tinea Capitis in Children; Gerald S. Light, M.D.; Vivian Lewis, M.D.

SPECIAL ARTICLES

- 1238 Memorial Tributes to Burton R. Corbus, M.D., Thomas Francis, M.D., and Albert C. Furstenberg, M.D.
- 1248 Governor Milliken's Six Steps to Attack State Health Problems
- 1294 Report on Sex Education Workshop; Judith Marr
- 1299 Community Health Week Review

GOVERNMENTAL-MEDICAL CARE PROGRAMS, Pages 1285-1286

PHOTO SECTION, Pages 1269-1276, inclusive

OTHER FEATURES

- 1221 Breaking News
- 1225 President's Page
- 1229 Officers Page
- 1234 Monthly Surveillance Report
- 1253 Editorial Views
- 1256 Our State Society
- 1256 Committee Calendar
- 1256 Mediscene
- 1257 Extract of Council Minutes
- 1258 County Societies
- 1277 News Briefs
- 1305 Ancillary
- 1306 In Memoriam
- 1316 Notes and Quotes

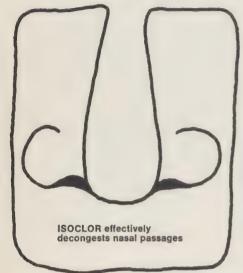
NEXT MONTH

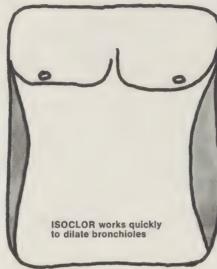
Scientific articles on Pulmonary Hypertension, Suppressible and Nonsuppressible Thyroid Function; a wrap-up of major congressional action on the tax standings of professional corporations, as well as the pros and cons of physician corporations; editorials on MDPAC, a new "social disease," and the woman's auxiliary; and the first in a forum discussion by several MSMS members of a timely topic — all are in the works for the January issue.

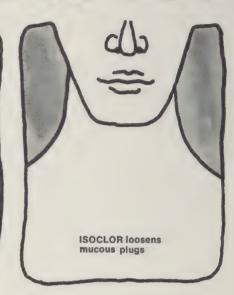
Watch also for a new format to highlight the first issue of the new year.

MICHIGAN MEDICINE is the official organ of the Michigan State Medical Society, published monthly under the direction of the Publication Committee. Published Semi-Monthly, Trimonthly in November and December; 26 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, \$9.00; single copies, 80 cents. Additional postage: Canada, \$1.00 per year; Pan-American Union, \$2.50 per year; Foreign, \$2.50 per year. Printed in USA. All communications relative to manuscripts, advertising, news, exchanges, etc., should be addressed to Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351. © 1969 Michigan State Medical Society.

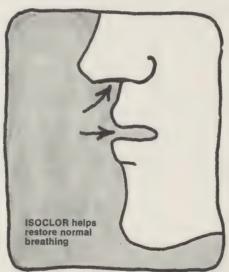
HERE ARE THE COLD FACTS:













ISOCLOR helps patients face the cold facts

ISOCLOR®

Isoclor provides quick, long lasting relief of respiratory congestion and discomfort brought on by common colds, influenza, and allergies. Isoclor contains chlorpheniramine maleate — one of the most potent and safest antihistamines. And pseudoephedrine HCl — a decongestant bronchodilator providing effective and long lasting relief for the entire respiratory tract. Both work to extend the range of relief.

Each ISOCLOR Timesule contains:

CONTRAINDICATIONS: Sensitivity to antihistamines or sympathomimetic agents. Severe hypertension or severe cardiac disease. PRECAUTIONS: Use with caution in patients suffering with hyperthyroidism. Patients susceptible to the soporific effects of chlorpheniramine should be warned against driving or operating machinery should drowsiness occur.

CAUTION: Federal law prohibits dispensing without prescription. SUPPLIED: Tablets: Bottles of 100 and 1000. Liquid: 4 oz. bottles, pints, and gallons; Timesules: Bottles of 50, 250, and 1000.

DOSAGE AND ADMINISTRATION:	Tablets	Liquid	Timesule
Adults:	1 q. 4 h.	2 tsp. q. 3-4 h.	1 q. 12 h.
Children 6-12 years:		1 tsp. q. 3-4 h.	
40-50 pounds:		3/4-1 tsp. q. 3-4 h.	
30-40 pounds:		½-¾ tsp. q. 3-4 h.	
20-30 pounds:		1/4-1/2 tsp. q. 3-4 h.	
15-20 pounds:		1/8-1/4 tsp. q. 3-4 h.	



ARNAR-STONE LABORATORIES, INC. QUALITY—RESEARCH—SERVICE SUBSIDIARY OF AMERICAN HOSPITAL SUPPLY CORPORATION Mount Prospect, Illinois 60056



MICHIGAN STATE MEDICAL SOCIETY

120 West Saginaw (P.O. Box 152) East Lansing, Mich. 48823 Area Code 517, 337-1351

PRESIDENT. Robert J. Mason, M.D. Birmingham PRESIDENT-ELECT Harold H. Hiscock, M.D. Flint SECRETARY. Kenneth H. Johnson, M.D. Lansing ASST. SECRETARY Brooker L. Masters, M.D. Fremont TREASURER. John R. Ylvisaker, M.D. Pontiac ASST. TREASURER. C. Allen Payne, M.D. Grand Rapids SPEAKER. James B. Blodgett, M.D. Detroit VICE-SPEAKER. Vernon V. Bass, M.D. Saginaw PAST PRESIDENT. James J. Lightbody, M.D. Detroit
COUNCIL CHR Ross V. Taylor, M.D Jackson VICE-CHAIRMAN Ralph R. Cooper, M.D Detroit
COUNCILORS: Sidney Adler, M.D. 1st Detroit Ralph R. Cooper, M.D. 1st Detroit Don W. McLean, M.D. 1st Detroit Milton R. Weed, M.D. 1st Grosse Pointe Park Robert K. Whiteley, M.D. 1st Detroit Ross V. Taylor, M.D. 2nd Jackson Robert M. Leitch, M.D. 3rd Union City Don Marshall, M.D. 4th Kalamazoo John R. Pedden, M.D. 5th Grand Rapids Ernest P. Griffin, Jr., M.D. 6th Flint John J. Coury, M.D. 7th Port Huron A. Carl Stander, M.D. 8th Saginaw Adam C. McClay, M.D. 9th Traverse City Robert C. Prophater, M.D. 10th Bay City Brooker L. Masters, M.D. 12th Escanaba J. Robert Franck, Jr., M.D. 13th Wakefield Harold F. Falls, M.D. 14th Ann Arbor Sydney Scher, M.D. 15th Mt. Clemens
EXECUTIVE DIRECTORHugh W. Brenneman East Lansing ASSOCIATE EX. DIR Warren F. TryloffEast Lansing

GENERAL COUNSEL.....Lester P. Dodd.......Detroit

LEGAL COUNSEL..... A. Stewart Kerr..... Detroit

ECON. CONSULTANT..... Clyde T. Hardwick...... Detroit HISTORIAN..... Wm. J. Stapleton, Jr., M.D. Detroit

ASS'T HISTORIAN...... Wm. M. LeFevre, M.D. Muskegon

SCIENTIFIC EDITOR John W. Moses, M.D., Detroit

EXECUTIVE EDITOR Herbert A. Auer

MANAGING EDITOR **Judith Marr**

ASSOCIATE SCIENTIFIC EDITORS Frederick J. Cady, Jr., M.D., Surgery Saginaw

Robert M. Daugherty, M.D., Basic Science East Lansing

Harold E. De Pree, M.D., Medicine Kalamazoo

Dean C. Elliott, M.D., Otolaryngology Petoskev

Tommy N. Evans, M.D., Obst.-Gyn. **Detroit**

E. Richard Harrell, M.D., Dermatology Ann Arbor

Dorin L. Hinerman, M.D., Pathology Ann Arbor

Samuel D. Jacobson, M.D., Medicine Detroit

Benjamin Jeffries, M.D., Psychiatry Detroit

Raymond S. Kurtzman, M.D., Radiology Detroit

A. Martin Lerner, M.D., Medicine

George H. Lowrey, M.D., Pediatrics Ann Arbor

Carl A. Moyer, M.D., Surgery Baraga

Charles E. Parkinson, M.D., Radiology **Battle Creek**

John C. Pierce, M.D., Medicine **Grand Rapids**

Frank H. Power, M.D., Surgery **Traverse City**

J. G. Turcotte, M.D., Surgery Ann Arbor

Alexander J. Walt, M.D., Surgery **Detroit**

Park W. Willis, III, M.D., Medicine Ann Arbor

Richard E. Wunsch, M.D., Medicine Traverse City

Publication Committee

Brooker L. Masters, M.D. Harvey C. Hansen, M.D. William A. LeMire, M.D. Don Marshall, M.D. Don W. McLean, M.D. Edward H. Rodda, M.D. Milton R. Weed, M.D.



A New Era

For Wayne State University School of Medicine

BY JOSEPH W. HESS, M.D. DETROIT

INTRODUCTION

Since its inconspicuous birth as a part-time activity of a few physicians on the staff of Harper Hospital over a century ago, Wayne State University School of Medicine has undergone a number of major transformations. It is now in the early stages of another complex and exciting transition as it moves to become one of the largest medical schools in the country and, at the same time, to revise and improve the quality and efficiency of its educational program and to reshape its role in the health care of the people of Michigan.

The developments in progress will be described under four general headings: training facilities, medical students, educational concepts and methods and relationship to health care in Michigan.

TRAINING FACILITIES

The Detroit Medical Center, the projected new home of Wayne State University School of Medicine, is rapidly becoming a physical reality. The existing facilities of Harper, Grace, and Hutzel Hospitals in the recent past have assumed key roles in the training of students, interns and residents. The new Medical Research Building has provided essential research space for basic science and clinical departments. The new Children's Hospital of Michigan, the new Basic Science Building and the medical library, all currently under construction, are scheduled for completion during 1970 and 1971. Work will soon be under way on the Webber Wing of Harper Hospital. This will become a major clinical teaching and research unit of the Medical School. When completed, there will be approximately 3,000 beds in the Medical Center. Also scheduled are the University Outpatient Building, a Postgraduate Education Center, and a new hospital for the City of Detroit. Parking structures and other service facilities are either under construction or are on the drawing boards.

In addition to facilities located in the Detroit Medical Center, the school has significant affilia-

The author is associate Professor of Medicine and Director, Division of Educational Services and Research, School of Medicine, Wayne State University.

tions with other hospitals in the community. The Veterans Administration Hospital in Allen Park, Sinai Hospital, and the Northwest Branch of Grace Hospital in Detroit all play important roles in the training programs of the Medical School. The community hospitals of Metropolitan Detroit can be expected to become increasingly valuable partners with the University in the education and health care programs of the future.

PHYSICIANS-IN-TRAINING

Over the past two decades, Wayne State University has increased the number of students admitted to the freshman class from 65 to 130. This is the largest percentage increase in enrollment of an established United States' medical school during this period. A further increase to 208 students is projected for the class entering September, 1971. Based on current projections, the total number of students in the undergraduate medical school will exceed 800 by the early 1970's and will reach 1,000 by 1975.

Some may wonder if the projected increases in class size will necessitate a compromise in the quality of students admitted. On the basis of recent trends, there appears to be little danger that this will occur. The academic quality of entering Freshmen, using grade point averages and Medical College Admission Test scores as criteria, has been on an upward trend in recent years and in-



SCIENTIFIC PAPERS

creasing numbers of students have bachelor's and master's degrees when they begin medical school. Paralleling this trend is a sharp increase in the number of applicants. There were 15 applications for every position in the class entering September, 1969. Present indications are that both of these trends will continue.

In the midst of these changes, the school has recognized that the relationship between a medical school and the society which it serves is a complex one and that the obligation to produce well-trained graduates is only part of its responsibilities. As our society struggles to provide greater equality of opportunity for all citizens, the medical school has an obligation to make sure that qualified students from disadvantaged minority groups are not excluded from medical school by criteria which are biased against them.

In order to more fully implement this philosophy, a program was inaugurated during the past year to select interested and capable black students and aid them in preparing for entry into medical school. Opportunities for needed remedial work is provided prior to entry and additional assistance will be available to them as they begin their medical studies. Financial support for this program has come from the National Fund for Medical Education, the Wayne County Health Foundation, and other sources. The Admissions Office and a faculty committee including physicians from the community have responsibility for guiding this program.

EDUCATIONAL CONCEPTS AND METHODS

The methods and philosophy which determine the manner in which medical students are trained are also undergoing major revisions. A new system of curricular organization reached the implementation stage during the 1968-69 academic year. The changeover to the new system will continue over the next two years.*

A major feature of the new curriculum is a movement away from the traditional fragmented teaching by isolated departments toward a coordinated, inter-disciplinary approach. Cell and organ systems and human and social behavior will become the focus for study. Integration of concepts derived from many scientific disciplines will be emphasized by making patients and clinical problems increasingly prominent subjects for study during the early years of medical school. Patient contacts now begin during the Freshman year and the frequency of these contacts will increase as ways of organizing them into effective learning experi-

ences for large numbers of students are developed.

The implementation of the new curriculum is under the guidance of interdepartmental committees. The students themselves are beginning to have an important voice in curricular affairs. In addition, more sophisticated methods for educational measurement, and instructional planning, and greater use of audiovisual and self-instructional materials will be incorporated into the program. Scientific research principles are being applied to educational questions. Faculty members and consultants trained in the education disciplines are infusing a variety of new concepts into the educational milieu.

In the years ahead, there will be decreasing emphasis on the faculty role as dispensor of basic information and increasing emphasis on their role as organizers, managers, advisors, and evaluators. Students will be given more opportunity for self-directed learning as attention is shifted from what has been taught to the more important question, what has been learned. The faculty is moving toward more explicit and detailed written definitions of the goals of the curriculum in terms of the knowledge and skills which every graduate should be able to demonstrate.

When the goals of the undergraduate curriculum have been described in sufficient detail and a system is developed for determining when a student has achieved all of them, it will be possible to shift from time spent at the institution to the demonstration of competence as the prime criterion for graduation. Once the feasibility of this concept has been proven, the efficiency and productivity of the medical school should be significantly enhanced.

RELATIONSHIP TO HEALTH CARE IN MICHIGAN

The faculty and physicians-in-training affiliated with the medical school have, for years, been major providers of health care for the Detroit area. Currently, a half million patients per year are receiving medical services through this mechanism. However, along with other activities, the manner in which the medical school provides and influences health care in Metropolitan Detroit and throughout the state is undergoing a shift in emphasis.

With the support of the Regional Medical Program, the Medical School has begun to establish a working relationship with three small hospitals in Detroit. The purpose of this relationship is to give the physicians and other health care personnel in hospitals traditionally isolated from the Medical School an opportunity to use the resources of the University to improve the care of patients in their institutions. If a satisfactory system can be developed with the first group of hospitals, the pro-

^{*} A more detailed description of the new curriculum may be obtained by writing to the Publications Office, Wayne State University School of Medicine, 1400 Chrysler Freeway, Detroit, Michigan 48207.

gram may be extended to others as funds and facilities will allow.

On another level, a move is under way to make the resources of the Medical School more accessible to community hospitals (both M.D. and D.O.) with non-affiliated intern and residency programs.

Programs in family and community medicine and comprehensive health care, now in the early planning stages, will have important implications for the health care needs of the metropolitan area and beyond. New types of health care workers (including new types of physicians) will be trained and research on health care delivery systems will be carried out. Through these and related programs, solutions for the pressing unmet health care needs of society will be sought.

These descriptions are cursory and oversimplified but they may give something of the flavor of the revolution in medical education which is upon this and all other American medical schools. The direction of the tide is clear. The question is not whether, but when. The opportunities are as immense as the problems.



MONTHLY SURVEILLANCE REPORT CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH FOR THE FOUR-WEEK PERIOD ENDING OCTOBER 24, 1969

	1969 This 4-Week Period	1968 Same 4-Week Period	1969 Total To Above Date	1968 Total Same Date	Total Cases for 1968
Rubella	120	93	3,920	1,627	1,953
Measles	24	19	313	291	352
Whooping Cough	34	28	152	375	429
Diphtheria	encome.	_	_	_	-
Mumps	186	183	4,170	13,379	14,655
Scarlet Fever &					
Strep Sore Throat	541	478	7,308	8,025	10,101
Tetanus	-	1	4	3	5
Poliomyelitis (paralytic)		1		1	3
Hepatitis	322	228	2,604	1,804	2,356
Salmonellosis					
(Other than S. typhi)	38	37	439	519	614
Typhoid Fever (S. typhi)	1		5		1
Shigellosis	33	53	243	246	346
Aseptic Meningitis	30	69	136	224	265
Encephalitis	13	10	105	81	114
Meningococcic Meningitis	3	2	95	75	94
H. Influenzal Meningitis	100	8	45	47	64
Tuberculosis	189	227	1,773	2,336	2,647
Syphilis	286	429	3,419	4,477	5,351
Gonorrhea	1,835	1,529	15,703	14,913	18,153

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director Michigan Department of Public Health Editorial Note: The author has discussed a very difficult problem from both diagnostic and therapeutic aspects. Frequently, close questioning of the patient with total deafness in one ear will indicate sudden loss of hearing years ago without any investigation having been done. The etiology of these otologic catastrophies has always been in doubt. This certainly led to a high level of educated guessing and to a wide divergence in investigational programs and in subsequent therapy. Dean C. Elliott, M.D., Associate Scientific Editor.

Adds Doctor Jaffe: "The study presented here is a prospective study. Certainly not all our cases revealed viral related illnesses. In these cases the etiology and pathophysiology still remain unknown, except in a few who prove to have specific diseases listed in this article."

Sudden Deafness

BY BURTON F. JAFFE, M.D. ANN ARBOR

There have been a number of new insights concerning sudden sensorineural deafness that makes timely a re-evaluation of this disease.

Sudden deafness should be considered a sign of more serious pathology until proven otherwise. Many medical and surgical conditions may first present as a sudden unilateral deafness, including hypercoagulation, acoustic neuromas, pontine infarcts, collagen diseases, multiple sclerosis, and syphilis. Only after full evaluation should the deafness be considered solely a cochlear disorder.

Sudden deafness is not rare, and most otolaryngologists will see a few cases each year. Based on my personal experience in the Ann Arbor area with a yearly average of about two cases per 90,000 population, the incidence is 1 per 45,000 per year. The state of Michigan will have 100 cases in a year, and the projected attack rate for the U.S.A. would be 4,500 cases per year.

ETIOLOGY

Most commonly a mild cold or upper respiratory infection precedes the sudden deafness. An article entitled "Head Colds and Viral Cochleitis" succinctly states this relationship. In large series one out of five patients will give a recent

The author is an instructor in the Department of Otorhinolaryngology, The University of Michigan, and is Chief of Otorhinolaryngology, Veterans Administration Hospital, Ann Arbor.

history of such an infection.^{2,8} During the past three years out of a total of 13 patients we have documented Mycoplasma pneumoniae infections in four patients and adenovirus infections in two patients by isolation of the agent from the nasopharynx and/or a four-fold or greater rise in convalescent serum antibody. It has long been recognized that mumps and measles can cause sudden deafness, as well as Herpes zoster, infectious mononucleosis, and chickenpox. It is probable that many common viruses will be implicated as more viral studies are performed.

THE ABRUPT NATURE of the sudden deafness suggests a vascular accident. Thrombosis of a vessel due to arteriosclerosis, sludging of red blood cells, and angiospasm have been postulated, although pathologic proof is lacking since patients do not die during the acute episode of sudden deafness. Many of our patients were young, from 20 to 40 years of age, without evident hypertension, diabetes, arteriosclerosis, or vascular disease. The possibility of thrombosis resulting from a viral-induced or spontaneous appearing hypercoagulable state was considered. (The term "hypercoagulation" is employed to designate a pathological acceleration of blood coagulation associated with intravascular thrombosis.) The tests used to demonstrate hypercoagulation were the prothrombin consumption (or activation rate), the two-stage prothrombin, the prothrombin time, and the thrombin time. Hypercoagulation has been documented in five out of 13 patients studied.4 We are currently calling back these patients to see if this hypercoagulation was transient or persistent.

Acoustic neuromas may present with a sudden unilateral deafness.⁵ The tumor may be in the cerebellar-pontine angle, in the internal auditory canal, or in the vestibule of the inner ear.⁶ The sudden deafness is attributed to occlusion of the internal auditory artery due to a sudden expansion from a hemorrhage into the acoustic neuroma. Surgical excision of the neuroma may improve the hearing.

Other diseases associated with sudden deafness are Meniere's disease, hyperviscosity syndromes (like macroglobulinemia or polycythemia vera), congenital or acquired syphilis, meningitis, pontine infarcts, sarcoid, hypothyroidism, collagen diseases, and multiple sclerosis. Pregnancy, particularly in the last trimester and early post partum period seems to be associated with sudden deafness.⁴ Kanamycin and ethacrynic acid have caused sudden deafness. Loud industrial noise usually gives a progressive loss, but in some workers a sudden loss occurs.⁷

HISTORY

Most patients are aware of a sudden deafness. However, some patients are more concerned with the sudden tinnitus or a sudden annoying pressure in the ear, and may not even be aware of a hearing loss. Other patients misinterpret the hearing loss and call it a "stuffy" feeling in the ear. The complaint of a "stuffy" feeling in the ear resembles Eustachian tube obstruction during an upper respiratory infection. The history is similar to the sensorineural loss from upper respiratory infection. However, an associated tinnitus, diplacusis, recruitment or vertigo, is more likely to be associated with a sensorineural loss than Eustachian tube obstruction.

DIAGNOSIS

Physical examination reveals a normal, mobile tympanic membrane. Whispering into the affected ear will reveal a loss of acuity as compared to the unaffected ear. The Weber test will lateralize to the unaffected ear at 512 and 1024 cps tuning forks, and the Rinne test may be positive.

An audiogram will confirm the diagnosis of a sensorineural loss. Special audiometric tests, as the short increment sensitivity index (SISI), bilateral alternate loudness balance test, speech discrimination score, tone decay, and Bekesy test should be performed to localize the site of the hearing loss (i.e., cochlear or retro-cochlear).

X-rays are essential to rule out enlargement of the internal auditory canal due to an acoustic neuroma, and may include mastoid views, tomography of the internal auditory canal, and posterior fossa myelograms when indicated. Blood studies should include a hematocrit test, white blood cell count, fasting blood sugar, serology, and urinalysis. Special tests for central nervous system disease, collagen diseases, or arteriosclerosis should be performed when clinically indicated.

Coagulation tests to identify hypercoagulation should be performed, since specific therapy may be indicated if hypercoagulation is present.

RECOVERY

It is generally believed that at least 50% of the patients with sudden deafness will recover spontaneously, although no large series of untreated control patients have been published. There has been no way to predict on the first day of sudden deafness who will or will not recover his hearing. In general, it has been assumed that prognosis is poorer the more severe the loss of hearing, or the longer the hearing loss persists.

Preliminary results in our 13 patients reveals a correlation between coagulation testing and prognosis. In five patients when hypercoagulation was detected, recovery was prompt and complete. In seven out of eight patients when coagulation was normal, recovery was either absent or only partial. This relationship may prove to be an important prognosticating factor.

We treat the acute episode of sudden deafness by using either low molecular weight dextran (M.W. 40,000),* 500 ml every eight hours intravenously for three days; or heparin subcutaneously approximately 10,000 units every 12 hours for one to three weeks depending upon recovery. Our series is still too small to establish the effectiveness of either therapy.

Recovery in some patients has been remarkable. Total recovery has occurred in three patients with losses of 100, 90, and 80dB., respectively.

SUMMARY

Sudden unilateral deafness most commonly follows a mild upper respiratory infection, and may be confused with serous otitis media. However, if the history includes tinnitus or transient vertigo, and if the tympanic membrane is normal and mobile a sensorineural loss should be assumed. Tuning fork and audiometric tests will confirm the diagnosis.

Sudden deafness should be considered a sign of more serious pathology until proven otherwise, since both medical and surgical diseases may present with sudden deafness. Acoustic neuromas, collagen diseases, and other systemic disorders should be considered as a primary underlying cause for the sudden deafness.

^{*}Rheomacrodex is available from Pharmacia, New York

Blood coagulation tests may reveal hypercoagulation, a pathological acceleration of coagulation. Preliminary studies indicate that normal coagulation is associated with poor recovery, and hypercoagulation is associated with good recovery.

Sudden deafness should be considered an otologic emergency since early treatment may be associated with better recovery. Even severe sensorineural loss may completely return to normal following therapy.

REFERENCES

- 1. Sataloff, J. and Vassallo, L.: Head Colds and Viral Cochleitis, Archives of Otolaryngology, 87:56-59 (Jan) 1968.
- 2. Jaffe, B.: Sudden Deafness an Otologic Emer-

- gency, Archives of Otolaryngology, 86:55-60 (July) 1967.
- 3. Van Dishoeck, H. A. E., and Bierman, T. A.: Sudden Perceptive Deafness and Viral Infection. Annals of Otology, Rhinology and Laryngology, 66:-963-980 (Dec) 1957.
- 4. Jaffe, B. and Penner, J.: Sudden Deafness Associated with Hypercoagulation. Transactions of the American Academy of Ophthalmology and Otolaryngology, 72:774-778 (Sept-Oct) 1968.
- 5. Pulec, J.: Comments on Translabyrinthine Approach to Acoustic Neuromas. Archives of Otolaryngology, 83:592-594 (June) 1966.
- 6. Angell James, J.: Discussion p. 352 Otolaryngologic Clinics of North America (Oct) 1968.
- 7. Kawata, S. and Suga, F.: Industrial Sudden Deafness. Annals of Otology, Rhinology and Laryngology, 76:895-902 (Oct) 1967.



IN MEMORY OF BURTON R. CORBUS, M.D.

BY JOHN R. PEDDEN, M.D. MEMBER, THE MSMS COUNCIL GRAND RAPIDS

To those of us who knew and practiced medicine with Burton R. Corbus, M.D., he represented the finest virtues of a physician.

He was wise in his knowledge of medicine; he was tolerant in his relationships to fellow physicians; he was generous in the gift of his time and energy to the people to whom he rendered care and in his advice to the younger physician.

He was held in high esteem in his local community as well as in the larger medical community. The profession of medicine has been enriched by the gifts and services of Doctor Corbus and we shall long honor him affectionately in our memory.

IN MEMORY OF THOMAS FRANCIS, JR., M.D. AND A. C. FURSTENBERG, M.D.

BY EDWIN H. PLACE, M.D., PRESIDENT WASHTENAW COUNTY MEDICAL SOCIETY

It has indeed been a blow to us and to the medical profession to have lost two such esteemed members of our medical society.

Albert Carl Furstenberg, M.D., and Thomas Francis, Jr., M.D., both of Ann Arbor, have been prominent in our local society and on the state, national and international level.

Both have been outstanding in their professions.

Doctor Francis has been known nationally and internationally for his role in the evaluation of the Salk vaccine. His positions, awards and memberships extended across the country and were international in scope. His writings on infectious diseases and virology were so numerous — some 250 — as to be mentioned only in number here. His death is a loss to our society, to the state and nation as a whole.

Doctor Furstenberg's early researches before the days of penicillin, antibiotics and the sulfanimides, were leaders in the field. He was recognized internationally for his work in otolaryngology. His writings and reports of studies have been so voluminous they can be mentioned only in general.

We all are very much at a loss to find anyone to take the places of two such men.

Laboratory Animal Science And Biomedical Research

BY WARREN G. HOAG, D.V.M., M.P.H., F.R.S.H. EAST LANSING

A major portion of medical research involves the use of experimental animals as biological yard-sticks for the evaluation of such things as drugs, vaccines and toxins as well as for models comparable to human disease situations. Sophisticated techniques, of biochemistry, of histochemistry, of electronmicroscopy, and the like, are applied to materials derived from experimental animals.

Unfortunately, the same degree of sophistication is not applied often enough to the animal model itself, its genetics, nutrition, environment, and husbandry. Too often, the quality of these latter variables place the experimental results in jeopardy or the interpretations open to question.

THE INVESTIGATOR, in designing his experiment, must determine what his variables are and how he will control or measure them. Such environmental factors as cage temperatures, humidity, barometric pressure, air movement, are parts of any experiment's records and could either singly or through interaction, become important to the results. Host factors such as genetics, immunological status, state of nutrition, etc., are also items which cannot be left to chance. It must be determined whether or not and how these can affect the experiment and the statistical design must be such that these effects can be measured.

Here it is well to mention latent infections and their relationship to statistical experimental design. Too often, attempts are made to randomize the effects of such infections and masked disease. The infectious process, its pathogenesis and the like, can be randomized only for a single point of time and the situation is soon altered. Randomization, by tables of random numbers, coin tossing, or other chance methods, is an attempt to set up experimental populations which can be statistically compared. The disease process in a single infected animal changes in time through the stages of incubation, symptomatic state and convalescence.

The author is director and professor of the Center for Laboratory Animal Resources at Michigan State University.

Starting with a population composed, let us say, of animals which are in these various stages of disease and also of susceptible animals, randomization into small groups of five or ten creates new epidemiological situations. Figure I shows a typical randomization by random number tables of a salmonella-infected mouse population into groups of five. The total population had an initial prevalence of 20 per cent. By setting up ten groups of five it was theoretically possible to have each group contain one infected animal. However, the epidemiological situation was soon altered by the numbers of susceptible and immune animals that were also present. This can be seen from Figure I, showing the changes in each "population" of five mice over a period of 12 weeks.

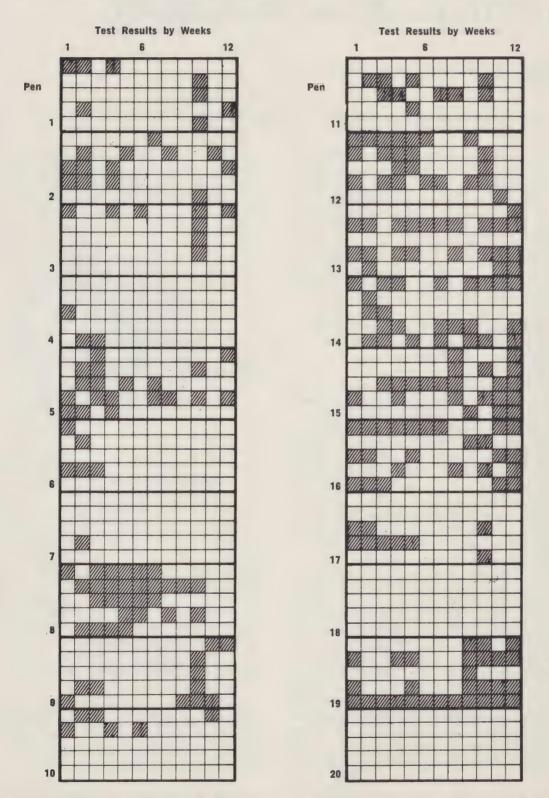
THE EFFECTS of any experimental variable must be interpreted in terms of the quality of the experimental tools, in most biomedical experiments, the animals involved. Laboratory animal science has to do with the attainment of the means of measuring this quality by seeking knowledge about many species of animals, their physiology and nutritive requirements, their husbandry and production, their diseases and treatment, their reactions to various environments, their behavior and social interactions. In addition, it has to do with the application of this knowledge in day to day maintenance of these animals ("laboratory animal care"). A further but not inseparable segment of laboratory animal science has to do with the orientation of this knowledge toward human health, the definition of naturally-occurring conditions in animals which can serve as experimental models for human diseases (comparative medicine).

Laboratory animal science, then, is an important part of biomedical research. "Part" is emphasizable since this science is so interwoven with experimental design and day-to-day research as to be never completely separable.

THE PROGRAM for laboratory animal science at Michigan State University is based on these concepts through the establishment, in 1967, of the Center for Laboratory Animal Resources. A

FIGURE I

RESULTS OF WEEKLY FECAL TEST FOR SALMONELLOSIS IN C57BL/6Ks MICE



NOTE: DARK SHADING INDICATES S. TYPHIMURIUM CULTURED FROM STOOLS. EACH ROW REPRESENTS ONE MOUSE. EACH PEN CONTAINED FIVE MICE.

part of The Institute of Biology and Medicine, the Center functions on a university-wide basis and is administered through the Dean of Veterinary Medicine. Its purposes are three-fold—research, teaching, and service in laboratory animal science—and encompass three principal areas:

- 1. Teaching and training of
 - a. graduate students
 - b. professional students in veterinary and human medicine
 - c. research assistants (animal laboratory technicians)
 - d. subcollegiate students (animal technicians)
- 2. Research in the field of
 - a. laboratory animal medicine
 - b. laboratory animal health, nutrition and behavior
 - c. comparative medicine
- Supply and service of laboratory animals as related to
 - a. procurement, quarantine and prophylaxis
 - b. preventive medicine, diagnosis and treat-

The teaching of veterinary students essentially involves insertion of various aspects of laboratory animal science into courses already in the curriculum. Course material has been reviewed to make room for such insertion. An example of how this functions is veterinary anatomy wherein time devoted to other species is shortened to allow time for introduction of the anatomy of monkeys, rodents, etc. In pathology, when oncology is presented, the tumors of rats, monkeys, and mice are added. Similar approaches are used in other basic science courses. In the clinical years students are assigned to the Center for Laboratory Animal Resources for exposure to practical laboratory medicine just as they rotate through large animal and small animal clinics, etc. The result is graduating veterinarians with a more widely comparative training who can apply their knowledge to the unusual pet or provide advice and assistance on a part time or consulting basis to the small research institutions.

For the graduate veterinarians desiring to acquire further training and experience in laboratory animal medicine, internships and residencies are provided to enable them to meet requirements for the examinations leading to specialty diplomate status in the American College of Laboratory Animal Medicine. For those veterinarians, physicians, or other doctorate-level scientists desiring advanced research degrees, it is possible to receive postdoctoral training by meeting the usual standards of specific departments such as physiology, pharmacology, pathology, microbiology, etc. The special emphasis in this case is on research in some phase of laboratory animal science.

ONE STEP being taken to help educate future

scientists is a course for graduate students which is oriented toward design of animal experiments. Such a course was made available in the Fall of 1968 and the content will emphasize the interaction of environmental factors, nutrition, disease, and genetics in animal studies. Students are thus made aware of the need to consider such factors in the evaluation of experimental results.

The training of research assistants or laboratory assistants in laboratory animal care is attempted by providing supplemental or optional courses in M.S.U.'s School of Medical Technology. Such additional training acquaints the laboratory technician with the various aspects of research animal care, handling, and usage techniques.

Another important area of training is aimed toward providing better trained animal caretakers. In cooperation with the Institute of Agricultural Technology, the Center inaugurated a short course program in Laboratory Animal Technology. Begun in September 1968, it offers two terms of courses followed by six months placement training and two more terms on campus. The placement training consists of actual job situations in cooperating pharmaceutical industries, veterinary clinics, and research animal facilities under selected supervision. Such a program provides training for young men and women directly from high school or supplemental education for experienced but informally trained animal technicians. The last six months (two terms) of the curriculum is designed for both the former and latter types of students but is optional for the former.

THE RESEARCH program for the Center is basically supported by a \$1 million five-year grant from the Laboratory Resources Branch of the National Institutes of Health. The investigations involve the "definition" of animals and other biological entities (birds, amphibia, reptiles, etc.) used as models for human disease problems. This "definition" includes physiological parameters such as blood values, metabolism, nutritional requirements, etc., as well as naturally-occurring disease conditions and behavior. A further emphasis is placed on comparative medicine, naturally-occurring conditions which make various species of animals particularly useful models for human disease research.

A further important function of any program in laboratory animal science is that of service. At M.S.U. this service is being developed on a University-wide basis providing consultation with scientists regarding animal health problems, management of animal colonies, planning of facilities, etc. The Center is also developing a centralized professionally-operated system of animal and animal supply procurement and distribution. Ancillary to this is a research and development program for new caging systems, environmental control methods, and watering, feeding, and care automation.

LABORATORY ANIMAL SCIENCE/Continued

Long range plans call for development of a biomedical animal research center which will innovate many of these new ideas and provide biological research scientists with animal quarters offering all conceivable, practicable, and measurable environmental systems. Research in such facilities will reduce animal wasteage and validate experimental results, yet provide for the comfort and care of the laboratory animals from every humane aspect.

Healthy, genetically-standardized animals under controlled environmental conditions will be needed in fewer numbers as compared to latent-diseased, random-source animals commonly used in converted laboratories or storerooms rarely provided even with summer air-cooling. Experiments in these latter situations often needed to be repeated or even discarded because of the side effects of these variables in the study. Furthermore, the results often cannot be justifiably and assuredly attributed to the drug, vaccine, or other variable being measured, the initial aim of the study. With the former conditions, good animal health, geneticstandardization, controlled environment, investigators can be assured of better and more evaluative experimental results.

Blood Glucose and Drug Levels In Normal Fasting Subjects Following Single Oral Doses Of Tolazamide and Chlorpropamide

BY ERVIN NOVAK, M.D., Ph.D. KEITH BORDEN, M.D. TRIESTE VITTI, PH.D. MARTHA HEARRON, M.S. KALAMAZOO

Tolazamide (Tolinase®) and chlorpropamide are orally effective hypoglycemic agents indicated for the treatment of mild to moderately severe maturity-onset diabetes mellitus. The primary activity of these sulfonylureas appears to be related to the release of endogenous insulin.^{1, 2} The chemical and structural formulae are:

1- (hexahydro-1-azepinyl) -3-p-tolylsulfonylurea

Chlorpropamide

1-[(p-chlorophenyl) sulfonyl 1]-3-propylurea

$$C1 \longrightarrow SO_2 - NH - CO - NH - CH_2 - CH_2 - CH_3$$

Clinically, tolazamide and chlorpropamide are considered roughly equal in terms of potency (on mg. to mg. basis) and in frequency of administration in responsive patients.^{9, 10}

The purpose of this paper is to report on a study designed to accurately determine glucose lowering ability and the drug concentration in the serum at intervals up to eight hours following a single 250 mg. dose of each drug.

MATERIALS AND METHODS

Sixteen men from the State Prison at Jackson, Michigan, volunteered for the study. None were obese (less than 20 percent over ideal body weight), and their ages ranged from 32 to 44 years. All subjects were considered clinically normal and had normal fasting glucose values. One subject had a mild abnormality of the glucose tolerance test which was not diagnostic of diabetes mellitus (by criteria of Wilkerson¹¹). Since this was a crossover study, the patients were assigned into two groups of eight each. The second part of the study was conducted three weeks after the first

The authors are with The Upjohn Co., Kalamazoo.

and was identical except that the drugs were reversed.

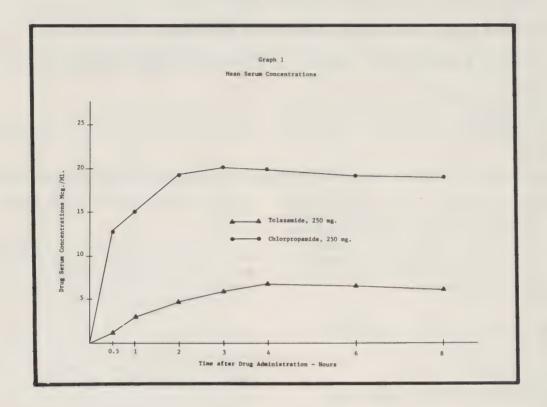
The subjects, who had been on a normal prison diet (high carbohydrate), were admitted to the study ward where they received no foods from midnight of the preceding day until completing the test (this included no coffee, tea or tobacco).

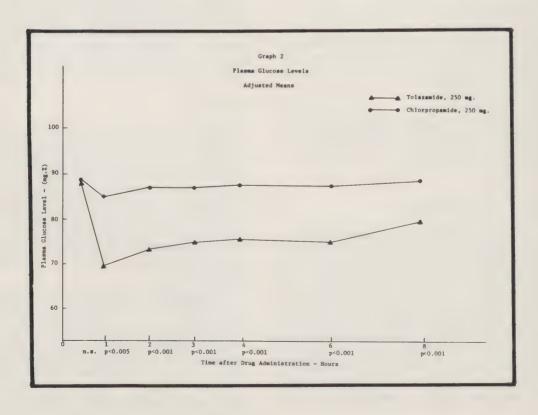
At 8:00 a.m., a fasting blood and urine specimen was obtained. Eight of the subjects (one group) were then given 250 mg. chlorpropamide each and the other eight 250 mg. tolazamide with 200 ml. tap water. Following this, blood and urine was obtained at ½, 1, 2, 3, 4, 6, and 8 hours. The technique used in collecting and assaying these specimens has been described.³⁻⁵ As stated, in three weeks the procedure was repeated to complete the crossover. Thus all 16 subjects received each drug, and the results that follow are based on 16 subjects on chlorpropamide and 16 on tolazamide.

RESULTS

The mean of the serum concentrations for each drug for each time period are shown in Graph 1. It can be seen clearly that the levels of tolazamide were about 15 mcg./ml. lower than those of chlor-propamide. The mean of the adjusted plasma glucose levels are shown in Graph 2, where the greater glucose lowering effect of the single dose of tolazamide than that of chlorpropamide is apparent. An analysis of covariance was performed and the significance indicated under the appropriate sample hour.

The other results from this study included some side effects, mostly headache, nervousness, and lightheadedness. These may have been drug related, but probably were caused by the long 18-hour fast. The total number of side effects ($\frac{7}{16}$ = 44%) were equal after both medications. All effects were transient, intermittent and of mild severity, except for one subject who was lightheaded for eight hours after the study and also complained of headache and nervousness for one to two hours post-medication.





DISCUSSION

Craig and co-workers⁶ administered tolbutamide (Orinase®) and chlorpropamide intravenously and found that equal doses produced similar decreases in blood glucose during a three hour period. In the present study, tolazamide, which is about five times more potent than tolbutamide (orally administered), was compared with equal (250 mg.) single oral doses of chlorpropamide. The difference in blood glucose lowering effect between them was significantly different at the .005 and .001 levels. The higher chlorpropamide levels can be explained by the slower rate of disappearance from the body and the reported differences in rates of absorption and volume of distribution.7 The half-life of chlorpropamide is about 36 hours while that of tolazamide is seven hours. Further, the volume of distribution of tolazamide7 is approximately twice the volume of distribution reported for tolbutamide or chlorpropamide.8 Thus this larger volume of distribution, together with a slower absorption rate,8 may account for tolazamide showing a relatively lower peak serum level than chlorpropamide.

These data cannot be directly applied to chronic or therapeutic administration. Tolazamide is reported to be comparable in potency to chlorpropamide during chronic administration even though it has a half-life of only seven hours. It would appear that the similarity of potency on multiple dosing is due to the greater single dose potency of tolazamide as described in this study. Further studies are required to determine how this might affect blood glucose levels and serum drug levels during chronic therapy.

SUMMARY

When single oral 250 mg. doses of tolazamide and chlorpropamide were given to normal volunteers using a crossover design, the tolazamide plasma drug levels were statistically significantly lower at all sampling times (1/2 hour to eight hours). The glucose lowering effect of tolazamide was greater than that of chlorpropamide. The higher chlorpropamide levels are explained by the lower rate of disappearance from the body (36 hours) as compared to tolazamide (seven hours), and the fact that the volume of distribution of tolazamide is about twice the volume of chlorpropamide.

REFERENCES

- 1. Volk, B. W. and Lazarus, S. S.: B-cell Hyperfunction After Long Term Sulfonylurea Treatment. Arch. Pathol. 78:114, 1964.
- 2. Chu, P.; Conway, M. J.; Krouse, B. A., and Youdner, C. J.: The Pattern of Response of Plasma Insulin and Glucose to Meals and Fasting During Chlorpropamide Therapy. Ann. Int. Med. 68:757,
- 3. Hoffman, W. S.: A Rapid Photo-electric Method for the Determination of Glucose in Blood and Urine. J. Biol. Chem. 120:51, 1937.
- 4. Forist, A. A. and Judy, R. W.: Spectrophotometric Determination of Antidiabetic Sulfonylureas and Sulfonylsemicarbazides in Serum. In preparation.
- 5. Toolan, T. J. and Wagner, R. L., Jr.: The Physical Properties of Chlorpropamide and Its Determination in Human Serum. Ann. N.Y. Acad. Sci. 74 (3):449-458, 1958.
- 6. Craig, J. W.; Miller, M.; Mills, F. D., and Nickerson, N.: A Comparison of the Acute Hypoglycemia Potencies of Tolbutamide and Chlorpropamide. Ann. N.Y. Acad. Sci. 74 (3):618-620, 1958.
- 7. Thomas, R. C.: Unpublished results.
- 8. Knauff, R. E.; Fajans, S. S.; Ramirez, E., and Conn, J. W.: Metabolic Studies of Chlorpropamide in Normal Men and in Diabetic Subjects. Ann. N.Y. Acad. Sci. 74 (3):603-617, 1958.
- 9. Sherwood, G. and Bressler, R.: Comparison of Chlorpropamide with Tolazamide in the Treatment of Diabetes Mellitus. Cur. Ther. Res. 10:399-404, Aug., 1968.
- 10. Grinnell, E. H.; Skillman, T. G.; Barse, R.; and Moller, Jr., C. L.: Clinical Effects of a New, Potent, Non-Toxic Sulfonylurea (Tolazamide). Cur. Ther. Res. 6 (7):433-441, July, 1964.
- 11. Wilkerson, H. L. C.: Diagnosis, Oral Glucose Tolerance Tests. Diabetes Mellitus, Diagnosis and Treatment, p. 31-34. American Diabetes Association, New York, 1964.

ACKNOWLEDGMENTS

The authors wish to thank Clarence Seckman and George Lund, Medical Division, The Upjohn Company, for assistance in supervising this study,

MEDLARS Center Bibliography Service Serves All Michigan

Michigan physicians may obtain complete free bibliographies on nearly any scientific topic through the services of a relatively new MED-LARS Center established nearly two years ago at the University of Michigan.

The center's services have been enlarged to serve the needs of the health science community throughout the State of Michigan for in-depth bibliographic service, supplementing the standard bibliographic and reference services of local medical libraries.

MEDLARS is the acronym for the National Library of Medicine's computer-based Medical Literature Analysis and Retrieval System.

The center is prepared to provide, free of charge, bibliographies of journal articles on specific subjects of interest. As requests are received they are translated into machine readable form and transmitted to the computer center at Ohio State University, where they are run against the total file of journal citations. The printed bibliographies are returned to the center where they are then forwarded to the requester. The process takes two or three weeks.

The total MEDLARS system contains more than 1,000,000 articles from over 2,300 journals in the health fields. Every month about 20,000 additional articles are added. Only those articles relevant to a specific question are retrieved from the computer's store, to be printed on paper or 3 by 5 cards, depending on the requester's preference. Searches are routinely made back through 1967, and special requests may be made for literature through 1964.

The U-M MEDLARS center is prepared to handle between 30 and 40 different requests each week. The printed bibliography will contain references to articles published as recently as three months ago. The regional center staff will offer counseling on bibliographic problems to potential users of the service, since it is not always immediately clear whether a MEDLARS search is appropriate.

The MEDLARS Center is located in Room 3490, Kresge Medical Research Building, The University of Michigan, Ann Arbor. Director is Mr. Robert E. Lawrence.

Michigan Scientist One of Three to Win Nobel Medicine Prize

The 1969 Nobel Prize for physiology and medicine was awarded Oct. 16 to three United States scientists — one an Owosso native and a graduate of Michigan State University.

He is Alfred D. Hershey, 60, of the genetics department of the Carnegie Institution of Washington, D.C. The other two winners are Max Delbrueck, 63, of the California Institute of Technology, and Italian-born Salvador E. Luria, 57, of the Massachusetts Institute of Technology.

The three joined together in the 1940s to do research into the mysteries of viruses and virus diseases. The faculty of the Caroline Institute in Stockholm, which selects the Nobel winners, cited the three men for their discoveries which give deeper insight into the nature of viruses and virus diseases and provide increased understanding of the mechanism of inheritance and the mechanisms that control the development, growth and function of tissues and organs.

Doctor Hershey received his degree in bacteriology from MSU in 1930 and his Ph.D. from MSU in 1934. He served on the faculty of Washington University, St. Louis, Mo., from 1934 to 1950, when he joined the Carnegie Institution's genetics department at Cold Spring Harbor, N.Y. He was named director in 1962.

HEART ASSOCIATION DISTRIBUTING LIST OF SODIUM CONTENTS

A "Directory of the Sodium Content of Selected Medicinals," prepared by the Michigan Regional Drug Information Network has been published by the Michigan Heart Association and is being distributed free to all hospital pharmacies and to physicians on request. The 39-page directory lists 1,166 preparations, and includes some of the popular patented remedies that are sold over the counter in drug stores.

Copies are now available from MSMS Headquarters of the complete index of scientific manuscripts which have appeared in the 1969 issues of MICHIGAN MEDICINE.

All 54 scientific articles which have been printed this year are listed in alphabetical order, along with authors and page numbers. Those interested in obtaining copies may write Index of Scientific Articles, MSMS Headquarters, 120 W. Saginaw St., East Lansing, 48823.

Tinea Capitis in Children

BY GERALD S. LIGHT, M.D. ANN ARBOR VIVIAN LEWIS, M.D. FLINT

Formerly, Microsporium audouinii has been considered the most common fungal pathogen implicated in tinea capitis in North America. However, recent reports^{1,2,3} have shown that Trichophyton tonsurans may cause endemic tinea capitis. The present retrospective study was undertaken to evaluate the etiologic agents in proven cases of tinea capitis treated over a two year period in a mid-Western pediatric out-patient clinic.

Patients with a clinical diagnosis of scalp ringworm were examined under a Wood's light in most instances. Fungus species isolated from hair and scales were identified by their morphologic characteristics and by standard culture techniques. All 47 cases with a positive fungus culture were entered into the study.

THE CAUSATIVE AGENT in 31 of 47 cases of tinea capitis was proven by culture to be Trichophyton tonsurans (Table I). Of the 31 cases, 27 occurred in Negroes, and 25 occurred in males (Table II). Fourteen of 16 cases of tinea capitis due to Microsporium audouinii occurred in Negroes and 15 of the 16 occurred in males. The Wood's light examination was positive in 68 per cent of cases of Microsporium infection (Table III).

Most cases of tinea capitis due to Microsporium infections can be diagnosed by the typical clinical picture and fluorescence under Wood's light. The scalp lesion is usually superficial with a well defined area of hair loss and scaliness. However, in the present study of 16 children with positive cultures for M. audouinii, five were negative by Wood's light examination. Ajello and associates⁴ considered similar findings indicative of actual, but nonfluorescent, M. audouinii scalp infections.

Since 1952, several authors^{1,2,3} have reported the increasing\ incidence of Trichophyton tonsurans infections in endemic areas of the United States. Population movements, particularly among migrant farm and factory workers, are suspected as the major medium of transmission. In the present study, 31 of 47 cases of tinea capitis were due to T. tonsurans. Such lesions are characteristically very superficial with irregular hair loss and occa-

Doctor Light is with the Department of Pediatrics, The University of Michigan, Ann Arbor. Doctor Lewis is a staff pediatrician with the C. S. Mott Children's Health Center, Flint.

TABLE I THE CAUSATIVE AGENT

Agent	Number	Per Cent
T. tonsurans	31	68.1
M. audouinii	16	31.9

TABLE II THE AGENT WITH RACE AND SEX

	Ra	се	S	ex
Agent	Negro	White	Male	Female
T. tonsurans	27	4	25	6
M. audouinii	14	2	15	1

TABLE III THE AGENT AND WOOD'S LAMP REACTION

	Agent	Tested	Positive	Per Cent Positive
T.	tonsurans	19	0	0
M.	audouinii	16	11	68.7

sionally suppuration. Trichophyton tonsurans lesions are nonfluorescent.

IT IS APPARENT that M. audouinii and T. tonsurans are the most common pathogens of tinea capitis in North America. Because the scalp lesions caused by T. tonsurans are nonspecific, a diagnosis by inspection may be difficult. The existence of nonfluorescent M. audouinii infection and the increasing incidence of the also nonfluorescent T. tonsurans infection diminish the value of Wood's light in the diagnosis of tinea capitis. It is obvious that whenever a diagnosis of tinea capitis is suspected, the use of culture techniques is imperative. The identity of the causative fungus is important not only for diagnosis, but also for proper treatment, prognosis and prevention of spread to others.

REFERENCES

- Miedler, L. J., Bocobo, F. C., and Eadie, G. A.: Trichophyton tonsurans infection of the scalp. J. Mich. Med. Soc. 59:1851-1856, 1960.
- Bocobo, F. C., Eadie, G. A., and Miedler, L. J.: Epidemiologic study of tinea capitis caused by T. tonsurans and M. audouinii. Public Health Rep. 80:891-898, 1965.
- 3. Georg, L. K.: Trichophyton tonsurans ringworm, a new public health problem. *Public Health Rep.* 67:53-56, 1952.
- 4. Ajello, L., Brumfield, G., and Palmer, J.: Nonfluorescent Microsporium audouinii scalp infections. *Arch. Derm.* (Chicago) 87:605-608, 1963.

Governor Milliken Outlines Six Steps Toward Attacking Michigan Health Problems



Gov. Milliken

The following are remarks given by Gov. William G. Milliken following luncheon Oct. 20 at the Michigan Union, University of Michigan, at the kick-off meeting of the 1969 Michigan Community Health Week. The speech was a major policy statement by the Governor on the subject of health manpower.

On this 100th anniversary of the University Hospital, we can be proud of our achievements in health care in Michigan.

THIS COUNTRY and this state have made achievements in medical care beyond anything that could have been imagined at the turn of the century.

But this very success has raised the question of whether we have the capacity to extend health care to all in society at a price they can afford.

OUR CRISIS is not one of technique and technology; the last decades have written a magnificent record. Our crisis is not necessarily even one of dollars — our gross national health expenditures have increased from 17 billion in 1955 to 55 billion in 1969. But Medicare and Medicaid experience has proved that providing dollars alone is not enough.

IT IS EVIDENT that the problem is not one of knowledge, but of effective organization for the delivery of services and of the best use of scarce money and manpower.

Progress in community health today requires of us an openness to change and a common commitment to assuring better health for all our citizens. And for this effort, we do not have 10 years; the demands are growing daily for results. What is at stake is the pluralistic, independent, voluntary nature of our health care system.

I want to tell you briefly about some of the activities we have started at the state level:

- (1) I have requested the Comprehensive State Health Planning Commission to convene a special interagency committee to consider the problems of food, nutrition, and health in Michigan as part of a nationwide effort. Among the assignments of this committee will be the determination of an adequate nutritional level and recommendations to assure that the populations for which the State has a responsibility are properly fed. Undernourishment breeds mental retardation, "laziness," and lack of physical and mental capability. We propose to mobilize against hunger.
- (2) I have appointed a Mental Health Program and Statutes Review Committee which, working with the Legislative Council, will recommend a revision of our mental health program statutes so that the state's mental health programs can be more effective in meeting community needs.
- (3) The bond issue passed last Fall by Michigan residents for sewage treatment facilities will remove the plaque of water pollution from more than 100 Michigan communities. We propose to continue to press for clean water and clean air.
- (4) I have appointed a Commission on Environmental Quality to review the growing threats to our environment. We propose to end the health hazards building up in our environment.
- (5) My proposals now before the Legislature for educational reform, by enabling our schools adequately to carry out their function in general education, in vocational education, in health education, and in education for living, and in making possible for equal opportunity will be, if enacted, a contribution to the health and well-being of Michigan citizens.
- (6) Finally, I will propose to the Comprehensive State Health Planning Commission that as part of their process of goal and priority setting, they formulate a program for Health Reform. Such a program would look at the actions that the State might take in health manpower development, in financing of health services for the poor, in regionalizing the governmentally sponsored health agencies, in assisting the private sector to develop greater comprehensiveness and continuity in care. Four per cent of the gross expenditures for health services now come from local, state, and federal government. That expenditure will grow to overwhelm us unless somehow, together, we can reorganize our efforts to make the system work for all citizens of Michigan.

Inner Sites...

In Cystitis...Azo Gantanol® focuses analgesic-antibacterial activity where it counts



Blood and urine: therapeutic antibacterial levels within 2 hours for up to 12 hours

Gantanol (sulfamethoxazole) produces prompt and prolonged therapeutic levels, in both blood and urine, with convenient b.i.d. dosage. Clinical response is usually obtained within 24 to 48 hours. The wide antibacterial spectrum of Gantanol includes E. coli and a variety of other susceptible gram-negative and gram-positive pathogens in urinary tract infections.

Azo (phenazopyridine HCl) effects specific mucosal analgesia, relieving the dysuria, discomfort and burning which are virtually always a part of acute urinary tract infections.

Gantanol (sulfamethoxazole) is readily diffused into interstitial fluids to provide efficient antibacterial activity at foci of infection. This distribution, plus continuous antibacterial levels in blood and urine, has afforded effectiveness in the majority of infections in which it has been used.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Urinary tract infections with associated pain or discomfort when due to susceptible organisms; prophylactically in urologic surgery, catheterization and instrumentation.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, newborn infants during the first three months of life, glomerular

Roche

Division of Hoffmann - La Roche Inc Nutley, New Jersey 07110 nephritis, severe hepatitis, uremia and pyelonephritis of pregnancy with gastro-intestinal disturbances.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

Adverse Reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

Azo Gantanol

(Each tablet contains 0.5 Gm sulfamethoxazole and 1,00 mg phenazopyridine HCl.)



Because peripheral vasodilation is needed now... and must often be continued

Roniacol Timespan (nicotinyl alcohol tartrate) can make a significant contribution to effective treatment of peripheral vascular disorders. It is directed specifically toward improvement of peripheral blood flow, relief of ischemic symptoms, and the long-term management of these conditions.

Specific pharmacologic action—Roniacol (nicotinyl alcohol) acts selectively by relaxing smooth muscle of peripheral blood vessels. Onset of action is smooth and gradual, rarely causing severe-flushing.

Relative freedom from side effects—Side effects

that may occur occasionally with Roniacol seldom require discontinuation of therapy.

Prolonged, continuous drug release—Prolonged peripheral vasodilation is provided by sustained-release Roniacol Timespan (nicoting alcohol tartrate) Tablets. Part of the drug becomes available immediately, the remainder continuously over a period of up to 12 hours, and dilation of constricted peripheral vessels in usually maintained. Thus, with a single dose of medication, patients can enjoy the benefits of increased peripheral blood flow in ischemic extremities for up to 12 hours.



Smooth peripheral vasodilation from initial dosage...extended with simple, well-tolerated, b.i.d. dosage

The prolonged action of Roniacol Timespan (nicotinyl alcohol tartrate) together with its other benefits offer a therapeutically practical measure in the long-term management of peripheral vascular disease—advantages especially important for older patients.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Conditions associated with deficient circulation; e.g., peripheral vascular disease, vascular spasm, varicose ulcers, decubital ulcers, chilblains, Meniere's syndrome and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

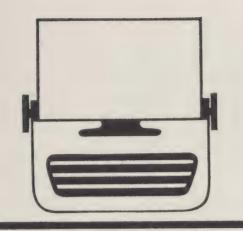
Dosage: 1 or 2 Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt—bottles of 50 and 500.



Division of Hoffmann - La Roche Inc. Nutley, New Jersey 07110

Art is a conception of peripheral vasodilation.

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back. The pain of earache was allegedly relieved by holding a hot roasted onion to the ear. For headache, a sovereign remedy was to wear a snakeskin round one's head. A realistic approach to pain relief 'Empirin Compound with Codeine Phosphate gr. 1/2 No. 3 Each tablet contains: Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 21/2, Aspirin gr. 31/2, Caffeine gr. 1/2. keeps the promise of pain relief 'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits. BURROUGHS WELLCOME & CO. (U.S.A.) INC. Tuckahoe, N.Y.



EDITORIAL VIEWS

Another Look at MVF

BY RICHARD E. DUSTIN, M.D. ADRIAN

(This editorial is reprinted from the Lenawee County Medical Society Bulletin)

Along with other physicians in the state of Michigan, I have recently received and examined the Michigan Medical Service Report of MVF programs.

Perhaps along with these physicians I have been concerned about the discrepancy between the anticipated 3.6% increase in fees annually, and the 22% reported in the past 30 months by Blue Shield.

Possibly the 3.6% increase could be considered a bit *low* in view of the fact that the economy is expanding at a rate closer to 5-6% annually, and there might be some reason to their observation that a 22% increase in fees could hardly be justified in view of the cost of living increase of only 10% in 30 months.

THE STATISTICS are computer-supplied and probably unassailable as far as accuracy is concerned, but the conclusions drawn from these figures can stand closer scrutiny. . .

On closer examination, the fallacy of this reasoning becomes obvious. The cost of living rise during this period is NOT the cost of staying in business and operating a physician's office!!!

Our expenses have not increased only by the cost of items we purchase, but by increases in many other items. Several items have been examined for changes in the same 30-month period

that Michigan Blue Shield considered in compiling its statistics, and here are the results:

% Cost inc	rease
Salaries 1	1.9%
Professional Management fees 4	4.5%
State Income Tax (B.A.T.)59	3.0%
Self-employment Tax (Social Security Tax) 2	2.9%
Employees SS Tax (Paid by Employer) 2	7.3%
Workman's Compensation Insurance 2	
Office Real Estate Tax	
Office Supplies 5	4.8%
	5.2%
Miscellaneous Office Expenses 2	4.2%
Malpractice Insurance	2.0%

In addition, expenses of employee-Koegh plan, 10% surtax, MESC are added expenses not calculable percentage-wise because they are a *new* additional expense.

TOTAL OF ABOVE ITEMS19.0%

But another consideration enters our calculations at this point. A rather vague one statistically, but probably even more devastating to the economics of office practice than those presented so far.

This is the massive increase in paper-work required of the physician — not his assistants alone — including, but not limited to office insurance papers for minor office consultations, camp physical examination forms, multiple insurance forms for the same illness, forms whenever anyone gets a simple lab test, Hospital's Medicare and utilization review committee reports, extended stay forms, diagnoses for laboratory slips, etc. . . . ad infinitum.

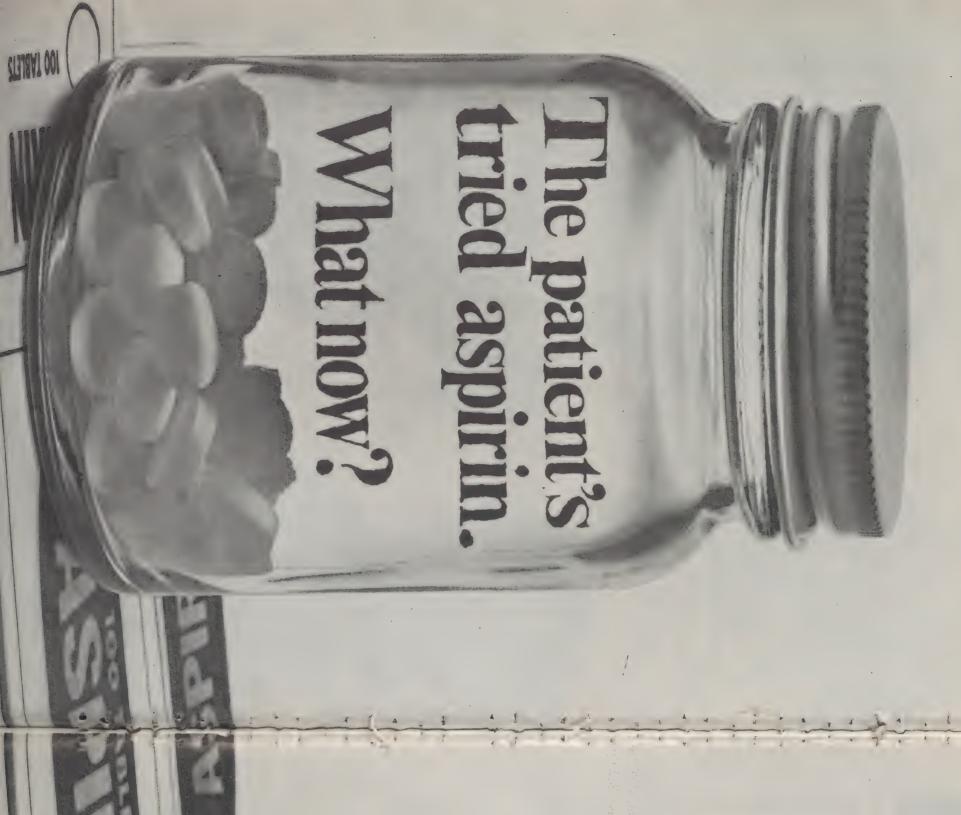
HIRING OF a new office assistant to process this paper-work (the portion not requiring a physician's personal attention), would nearly double the 19% increase calculated previously.

This increase in requirements of physicians time for such items must be met at the expense of time available for patient-care, resulting in fewer patients to share the expense.

PSYCHIATRISTS

Liberal Fringe Benefits. Salaries determined on individual basis. Henry Ford Hospital invites all candidates interested in a staff psychiatrist position to contact.

Han Von Brauchitsch, M.D.
Chief, Department of Psychiatry
Henry Ford Hospital
2799 West Grand Blvd.
Detroit, Michigan 48202



more than a non-prescription analgesic for pain relief. Especially after self-medication has failed. There's a good chance your patient needs

single, non-narcotic preparation, it helps relieve pain and associated anxiety and tension. may in part be a reflection of anxiety, Equagesic is worthy of consideration. In a Because continuing, increased pain and discomfort

meprobamate and ethoheptazine citrate with aspirin) Wyeth

Contraindications: History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

slowed reactions and impaired jugment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal fendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could Precautions: Keep out of reach of children, Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant chaused reactions and imparied indoment and

be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic or instory. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, eachymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet

Wyeth Laborateries Philadelphia, Pa. Wyeth



COMMITTEE CALENDAR

Many MSMS committees have scheduled meetings for this month and the new year, as they get deep into their work. Following is a recent list of meetings planned:

Thursday, Dec. 4
Committee on Rehabilitation and
Nursing Homes
MSMS Headquarters, East Lansing
Chairman: L. L. Davis, M.D.,
Mt. Pleasant

Tuesday, Dec. 9
Committee on Quackery
Rehabilitation Institute
Chairman: J. N. Schaeffer, M.D.,
Detroit

Tuesday, Dec. 9
County Societies Committee
MSMS Headquarters, East Lansing
Chairman: J. J. Coury, M.D.,
Port Huron

Wednesday, Dec. 10
The Council
MSMS Headquarters, East Lansing
Chairman: Ross V. Taylor, M.D.,
Jackson

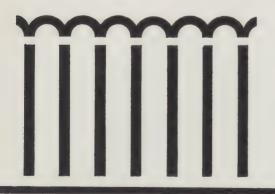
Wednesday, Dec. 10
Subcommittee on Study of Cancer
Registry Systems
MSMS Headquarters
Chairman: C. Allen Payne, M.D.,
Grand Rapids

Wednesday, Dec. 10
Committee on Alcohol and Drug
Dependence
MSMS Headquarters, East Lansing
Chairman: H. A. Raskin, M.D.,
Southfield

Thursday, Dec. 11
Committee on Postgraduate Medical
Education
Towsley Center, Ann Arbor
Chairman: Harry A. Towsley, M.D.,
Ann Arbor

Thursday, Jan. 8
Committee on Maternal and Perinatal
Health
MSMS Headquarters, East Lansing
Chairman: James E. Harryman, M.D.,
Muskegon

Friday, Jan. 23
Committee on Mental Health
Sheraton-Cadillac Hotel, Detroit
Chairman: Benjamin Jeffries, M.D.,
Harper Woods



OUR STATE SOCIETY

Michigan Mediscene

Nov. 30-Dec. 3 – American Medical Association Clinical Convention, Denver

Dec. 1 – 9th Annual Thyroid Workshop, Wayne County Medical Society, Detroit

Dec. 10 – MSMS COUNCIL, MSMS Headquarters, East Lansing, 9:30 a.m.

Dec. 15 – American College of Emergency Physicians, MSMS Headquarters, East Lansing, 5:00 p.m.

1970 Meetings

Jan. 18 – Michigan Academy of General Practice, Board of Directors, MSMS Headquarters, East Lansing, 2:00 p.m.

Jan. 26 – MSMS WOMAN'S AUXILIARY, MSMS Headquarters, East Lansing, All Day

Jan. 28 – MSMS COUNCIL, MSMS Headquarters, East Lansing, 9:30 a.m.

Mar. 11 – MSMS COUNCIL, MSMS Headquarters, East Lansing, 9:30 a.m.

Mar. 25-26 — 9th ANNUAL CONFERENCE ON MATERNAL AND PERINATAL WELFARE, Pick-Durant Hotel, Flint

Apr. 22 – MSMS COUNCIL, Towsley Center, Ann Arbor, 9:30 a.m.

Apr. 23-26 – MICHIGAN STATE MEDICAL AS-SISTANTS SOCIETY ANNUAL MEETING, Pontchartrain Hotel, Detroit

Apr. 30 – 1970 MSMS CONFERENCE ON MEDI-CAL ASPECTS OF HIGH SCHOOL SPORTS, Towsley Center, U-M, Ann Arbor (tentative)

May 21-22 – MSMS ANNUAL MATERNAL HEALTH CONFERENCE, Kellogg Biological Station, Gull Lake

May 27 – MSMS COUNCIL, MSMS Headquarters, East Lansing, 9:30 a.m.

June 17 – MSMS COUNCIL, MSMS Headquarters, East Lansing, 12:00 noon

June 21-25 – American Medical Association Annual Convention, Chicago

July 23-25 – MSMS COUNCIL, Grand Hotel, Mackinac Island

Sept. 20 – MSMS COUNCIL, Sheraton-Cadillac Hotel, Detroit, 9:30 a.m.

Sept. 23 – MSMS COUNCIL, Sheraton-Cadillac Hotel, Detroit, 8:00 a.m.

Sept. 25-Oct. 2 — American Academy of General Practice Scientific Assembly, San Francisco

Nov. 4 – MSMS COUNCIL, MSMS Headquarters, East Lansing, 12:00 noon

Nov. 29-Dec. 2 – American Medical Association Clinical Convention, Boston

Dec. 9 – MSMS COUNCIL, MSMS Headquarters, East Lansing, 9:30 a.m.



Meeting of Sept. 28-Oct. 1

Extract of MSMS Council Minutes

MARMP — The Council authorized Don Marshall, M.D., Kalamazoo, to continue as the MSMS representative to MARMP. Now president of the association, Doctor Marshall was cited for an outstanding job with the Regional Medical Programs.

GUESTS – The Council approved development and use of a schedule for inviting guests to its meetings during the coming year. Scheduling could be worked out so that four or five Council members would be asked to bring one guest to certain meetings – each Council member bringing one guest per year. Guests could travel to the meetings with their councilor hosts.

MHA MANUAL — The Council approved in principle the use of the proposed Michigan Hospital Association Consent Manual and forms, recognizing them as guides

MSMS Requests AMA Develop Quackery Folder

A letter has been mailed from The MSMS Council requesting that the AMA develop a small, educational folder for distribution in doctors' offices and other places warning elderly people about quackery. The Council sent the letter at the suggestion of the Public Relations Committee.

only and entitled to usage or adaptation, together with the similar forms promulgated by the AMA.

MALPRACTICE — The Council authorized formation of a special joint committee with an appropriate committee of the State Bar to explore in depth possible solutions for the increasing malpractice litigation.

ALCOHOL — The Council approved liaison between the MSMS committee on Alcohol and Drug Dependence and an appropriate committee of the State Bar for the review of various drug laws.

MDPAC — The Council referred to the Finance Committee a motion to authorize a \$3,500 grant to MDPAC for the purpose of carrying on that organization's educational programs. Those programs, specifically a one-day conference in Lansing in November, require several thousand dollars and MDPAC is seeking support from MSMS for this venture. No funds are sought for political activity or support of candidates.

AWARDS — The Council referred to the Awards Committee a suggestion to present awards or scrolls for long service to MSMS, to councilors or delegates, for instance.

News of Council elections and other highlights appeared in the October News Extra.

AMA Suggests Physicians Work for Medicaid Economies

Emphasizing that the need in meeting health care requirements of the poor is to encourage participation by more physicians rather than fewer, the AMA has asked MSMS members to help implement a four-point program for refinement and economies in the Medicaid program.

The four recommendations made by AMA are:

(1) Vigorous emphasis on review by local medical societies of the use made of expensive hospital and nursing home facilities.

(2) Eradication by the medical profession of the isolated abuses by physicians in making unwarranted charges or other procedures that boost costs.

(3) Urging all medical societies and individual physicians wherever possible to bring health services into the low-income communities, where it will be more convenient to the patients and less expensive.

(4) Active review by medical societies to make certain the quality of health care provided to everyone is maintained, even while cost efficiencies are effected.



COUNTY SOCIETIES

EMERGENCIES, SEX EDUCATION LENAWEE TOPICS

Robert Kandel, M.D., Henry Ford Hospital, Detroit, and Lenawee County Sheriff Richard Germond gave reports on current problems of emergency medicine before the October meeting of the Lenawee County Medical Society. In November, the county society heard a discussion of the problems of establishing state-wide standards of sex education programs in the schools by Eleanor Skufis, M.D., Adrian.

BAY-ARENAC-IOSCO HEAR HEALTH DEPARTMENT SPEAKER

At their October meeting, members of the Bay-Arenac-Iosco County Medical Society heard a talk by Hermann A. Ziel, M.D., director of the Michigan Public Health Department Medical Care Administration. The Society's November meeting featured a report on the Mobile Meals program by members of the Woman's Auxiliary to the county society.

CHICAGO PHYSICIAN FEATURED AT GENESEE PRESIDENTS' DINNER

Philip Thorek, M.D., author, film essayist and surgeon-in-chief, American Hospital of Chicago, was guest speaker at the past presidents' dinner of the Genesee County Medical Society, early in November. The dinner honored out-going GCMS president Donald R. Bryant, M.D.

INVESTMENTS, HEALTH CENTERS SUBJECTS OF WASHTENAW MEETINGS

Tax sheltered investments were the subject of the October meeting of the Washtenaw County Medical Society. An expert in tax law from Detroit and representatives for several tax sheltered investments, such as cattle and oil, were present to advise society members. Society members heard a talk on the five basic responsibilities of Community Mental Health Centers by Philip Margolis, M.D., Ann Arbor, at their September meeting.

EDEMA TOPIC OF KALAMAZOO MEETING

Aldosterone states, the nephrotic syndrome and other cases of renal edema were discussed during a talk on "Diuretics in Edema" given before the Kalamazoo Academy of Medicine by William M. Hamby, M.D., chief, renal-hypertension medical section, Edward Hines, Jr., Hospital.

OAKLAND SOCIETY, AUXILIARY HOLD JOINT MEETING

The Oakland County Medical Society and its Woman's Auxiliary held a joint meeting in November with guest speaker, Armin Grams, Ph.D., head of the Human Development Program of the Merrill-Palmer Institute of Human Development. Doctor Grams's topic was: "Rearing Children in a Changing World." "The Malpractice Situation" was the topic of the society's October meeting. Speakers were three Oakland County lawyers and Morris A. Riley of the MSMS staff, who presented resumes of current and proposed legislation on medical problems.





Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®: Glyceryl guaiacolate, 50 mg; Dextromethorphan hydrobromide, 7.5 mg. A. H. Robins Company, Richmond, Virginia 23220

A-H-ROBINS

TO: Our Advertisers:

We extend our sincere thanks for your patronage during 1969.

Your support of Michigan Medicine has enabled us to produce a publication worthy of its place in medical literature.

Your support also makes it possible to provide important socio-economic, political, legal information for our members.

Our members have found your advertisements informative and helpful in securing or prescribing accepted products and services during the past year.

Our best wishes for a successful and prosperous 1970.

Michigan Medicine.



THE G. A. INGRAM COMPANY 4444 Woodward Avenue, Detroit, Michigan 48201 Telephone: TEmple 2-4444



Ornade Spans

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.

Prompt relief from nasal congestion and hypersecretion due to colds.

Before prescribing, see complete prescribing information in SK&F literature or PDR. Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.

Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.

Usage In Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.

Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I131 uptake; discontinue 'Ornade' one week before these tests.

Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia.

Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported. Supplied: Bottles of 50 capsules.

One capsule q12h for round-the-clock relief





a message from the president

The Michigan Association for Regional Medical Programs (MARMP) is one of 55 regional programs in the country whose common aim is to increase the availability, accessibility, and quality of health care in the areas of heart disease, cancer, stroke, and related diseases — all of which account for over 70% of deaths, both in Michigan and nationally. Included in these broad concerns are: 1) the continuing reassessment of the health delivery system; 2) the provision of increased opportunities for continuing education of the health care team; 3) the control of rising costs without sacrificing the quality of health care; and 4) the promotion of new health careers.

MARMP has just completed its second year of existence. Despite inevitable headaches, real progress has been made. Fifteen projects have been funded, six more have been approved and are awaiting funding, and two others are now being considered in Washington. Several projects are also in various stages of development.

In addition, a program plan has been developed to provide general information to potential project sponsors. To supplement this, more detailed and comprehensive plans have been developed to guide MARMP in the implementation, coordination, and financing of stroke and cancer programs More recently, guidelines for the preparation and review of

proposals for educational programs have been approved by the Regional Advisory Group. These four documents are available on request. It is anticipated that similar regional plans will soon be developed to guide programs in the area of heart and chronic respira-

tory diseases Public Law 89-239 which governs us is new. It must be

Don Marshall, M.D. used as intended: to improve patient care by improving the education, abilities and facilities of the several members of the entire health team. This law promotes cooper-

ation, local initiative, self-analysis, self-improvement, intercommunication and collaboration - not for Washington, not for any medical school, but so that every Michigan patient will get improved and up-to-date care. This is our I invite you, from any Michigan hospital staff, school, or health group, to consider ways in which you would like to participate actively in this program. If you have an

idea for a project, contact our East Lansing office.

Don Marshall, M.D., President

Heart Disease

Coronary Care Unit Training Programs Sponsor:

Michigan Heart Association **Project Director:**

Mr. Oliver H. Wendt Status: In operation

Amount Budgeted: Expended:1 \$72,995

This coronary care unit training program offers two week courses for nurses and one to three day seminars for physicians who function in coronary and intensive care units. The courses are held in various areas of the state. In addition, the project has developed programmed learning texts to be used with electronic teaching machines, for loan to hospitals with coronary care units or hospitals planning units in the near future.

Physician Education in Hypertension **Sponsor:**

Michigan State University **Project Director:**

Dr. Robert M. Daugherty

Status: In operation Amount Budgeted: Expended: \$14,490

A physician education program in the management of hypertension and hypertensive heart disease is being implemented by Michigan State University, in cooperation with E. W. Sparrow Hospital and Lansing community physicians. The physicians selected for the educational program attend the hypertension clinic one day a week for three months.

Survey of Emergency Care **Electronic Equipment** Sponsor:

Wayne State University **Project Director:**

Dr. Henry L. Green Status: In operation

Amount Budgeted: Expended: \$13,601 \$8,643

This program is surveying hospitals in the Metropolitan Detroit Area to assess personnel practices with respect to electronic equipment in coronary and intensive care units and emergency rooms. The survey also determines potential hazards in the use of such equipment and provides pertinent safety data about specific equipment to personnel in the units surveyed.

Physician Training in Cardiovascular Care Sponsor: Mercy Hospital. Benton Harbor **Project Director:** Dr. Frank H. Bunker

Status: Approved regionally and federally, but not yet funded.

Amount recommended: \$46,074 The program will provide educational programs in cardiovascular diseases for physicians in Berrien. Cass and Van Buren counties through visiting consultants, inter-hospital conferences, and monthly clinics. Additionally, a cardio-vascular center will be established at Mercy Hospital.

Physician Training in Satellite Hospitals Sponsor: Blodgett Memorial Hospital, Grand Rapids **Project Director:**

To be appointed Status: Approved regionally. now being reviewed at the federal level.

Amount recommended: \$87,792 Blodgett Hospital, in cooperation with ten smaller, surrounding hospitals, will develop a physician education program in cardiovascular diseases to be conducted in the smaller hospitals. It will include the services of a replacement physician to enable local physicians to attend educational programs at Blodget Hospital or other medical centers.

Stroke

Regional Stroke Base Center Sponsor:

Wayne State University **Project Director:**

Dr. Ray B. Bauer Status: Approved regionally and federally, but not yet funded

Amount recommended: \$54,400 The Regional Stroke Base Center will provide professional consultation to the cooperating stroke centers, assist in the design of educational opportunities to meet their needs and be responsible for overall evaluation of the program.

PROGRAM **ACTIVITIES**

Cooperating Stroke Centers (3) Sponsor:

Detroit General Hospital Project Director: Dr. John Gilrov **Amount Recommended:**

\$240,022

Sponsor:

Detroit Osteopathic Hospital Project Director: Dr. Louis E. Rentz

Amount Recommended:

\$124,619 Sponsor: Michigan State Uni-

versity, Lansing Rehabilitation Center, and Sparrow Hospital

Project Director: Dr. John F. Lane **Amount Recommended:**

\$81,916 Status: Approved regionally and federally, but not yet funded.

Acute care stroke units, to be established at the above locations, will serve as demonstration and training centers for physicians and allied health personnel. New methods of diagnosis, treatment and rehabilitation of acute stroke patients will be demonstrated. Additionally, teams of experts from the stroke units will visit participating facilities for the purpose of conducting consultations, teaching rounds, and seminars.

Stroke Education Program Sponsor:

Michigan Heart Association **Project Director:**

To be appointed Status: Approved regionally and federally, but not yet funded.

Amount recommended: \$65,038 This program proposes to educate Michigan people regarding predisposing factors and symptoms of stroke. This is to be achieved through the production of television and radio announcements, pamphlets, magazine and newspaper articles, speakers kits, audiovisual materials, school health programs, group seminars, hospital and physician society meetings.

¹ All expended amounts are based upon preliminary fiscal information and are subject to further adjustment.

All Three Categorical Diseases

Continuing Education in Heart Disease, Cancer and Stroke for Nurses

Sponsor:

University of Michigan

Project Director:

Miss Geraldine Skinner, R.N.

Status: In operation

Amount Budgeted: Expended: \$74,069 \$65,962

This program is concerned with planning and implementing continuing education programs in heart disease, cancer and stroke for nurses throughout the region. Special attention is given to needs of directors of in-service education and community hospitals in the development of their own educational programs.

Drug Information Center Sponsor:

University of Michigan Project Director:

Mr. Robert E. Pearson Status: In operation

Amount Budgeted: Expended: \$81,861 \$66,543

The Drug Information Center provides information to physicians, pharmacists and other health professionals throughout the region. The service is available 24 hours a day, seven days a week. In addition, this project will establish educational programs in hospitals and will work with community hospitals to analyze drug therapy patterns as they relate to heart disease, cancer, and stroke.

Comprehensive Health Care
of the Urban Poor
Sponsor: Wayne County
General Hospital
Project Director:
Dr. Bernard A. Bercu
Status: Approved regionally,
now being reviewed at the
federal level.

Amount recommended: \$437,899

This program for indigent persons proposes to establish a modern and comprehensive screening, diagnostic and treatment center in the outpatient department of Wayne County General Hospital. Procedures in the clinic will be automated and computerized to obtain rapid information and to establish a new medical record sys-

tem. The clinic will serve as a consultation center for others wishing to develop similar programs

Additionally, the project will include new ways to use non-professional personnel. Future plans are to combine this program with their training. This project was developed from the previously funded project, "Non-Professional Staff Utilization."

Non-Professional Staff Utilization **Sponsor: Wayne County** General Hospital **Project Director:** Dr. Bernard A. Bercu Status: Terminated Amount Budgeted: Expended: \$20,637 This program was designed to study and determine ways that non-professional staff could assist physicians in patient care. Planning activities resulted in the development of the project. "Comprehensive Health Care

Evaluation and Data Collection

federal level.

Coordinated Data

of the Urban Poor," which is

presently being reviewed at the

Collection and Analysis Sponsor: Michigan Department of Public Health **Project Director:** Dr. Robert F. Lewis Status: In operation Amount Budgeted: Expended: \$299,059 \$130,573 Through a population sample survey and extension of information related to deaths and rates from heart disease, cancer, stroke and related diseases, this program is defining target populations needing care, and measuring the performance of the health care delivery system.

Physician Attitude Survey Sponsor:

University of Michigan Project Director: Dr. Floyd C. Mann

Status: In operation Amount Budgeted: Expended: \$93,875 \$84,414

The survey will identify Michigan physicians' attitudes toward their present ability to keep abreast with medical ad-

vances, their appraisal of present means of postgraduate education, and their receptivity to new approaches in continuing education. In addition, this project is identifying key physicians in the dissemination of medical information.

Evaluation of Medical Care Sponsor:

University of Michigan Project Director:

Dr. Donald C. Smith
Status: In operation
Amount Budgeted: Expended:
\$122,769 \$50

The medical care rendered to patients with heart disease, cancer or stroke in a selected urban community is being considered by this program. This includes working with community representatives to understand and describe the current care being delivered to patients, identifying those elements where the system can be favorably changed, developing methods for producing these changes, introducing them into the system, and measuring the effects of these changes.

Planning Activities

Planning Staffs (4)

Sponsor:

Michigan State University Project Director:

Dr. L. George Suhrland Amount Budgeted: Expended: \$243,567 \$192,706

Sponsor:

Wayne State University Project Director:

Mr. Marvin D. Meltzer Amount Budgeted: Expended: \$173,046 \$147,601

Sponsor:

University of Michigan Project Director:

Dr. Harry A. Towsley Amount Budgeted: Expended: \$135,271 \$88,624

Status: In operation

Sponsor: Michigan Department of Public Health

Project Director: Vacant
Amount Budgeted: Expended:
\$58.147 \$8.558

Status: Terminated

Planning staffs at the above institutions coordinate activities concerned with Regional Medical Programs within their respective institutions, with

other agencies interested in similar matters, and with the Corporation staff. In addition, the staffs plan for and encourage new activities in heart disease, cancer, stroke and related diseases.

Continuing Physician Education Sponsor:

Zieger/Botsford Hospitals
Project Director:

Dr. Ellis Siefer (acting)
Status: In operation

Amount Budgeted: Expended: \$99,299 \$81,729

During the past year this program has been developing, in cooperation with the American Public Health Association's Professional Examination Service, a survey of osteopathic physician knowledge and practice in heart disease, cancer and stroke to determine needs for continuing education. The information obtained in this survey will be used to plan for and develop methods to meet the identified needs.

Postgraduate Dental Education Programs Sponsor:

University of Michigan Project Director:

Dr. William R. Mann

Status: In operation Amount Budgeted: Expended:

\$37,012 \$17,700

Planning for the development of postgraduate dental éducation programs to meet the needs of heart, cancer, and stroke patients is being carried out by this program. Studies currently in process include assessment of present and future needs in dental continuing education, and development of methods to meet the identified needs.

Corporation Operations
Amount Budgeted: Expended:
\$255,074 \$177,143

Members of the Corporation and Regional Advisory Group

Organizations

American Cancer Society, Michigan Division

Mrs. Clio Van Valkenburg

Michigan Association of Osteopathic Physicians and Surgeons

*Dr. Dorothy E. Carnegie Michigan Cancer Foundation

Dr. Michael J. Brennan Michigan Department of

Public Health
*Dr. R. Gerald Rice

Michigan Health Council
Mr. John A. Doherty

Michigan Heart Association Dr. Edward W. Green

Michigan Hospital Association *Mr. Ronald D. Yaw

Michigan Nurses Association Mrs. Esther P. Benjamin

Michigan Osteopathic Hospital Association

Mr. Seymour M. Cantor

Michigan State Dental Association

Dr. Gerald H. Bonnette

Michigan State Medical Society

*Dr. Don Marshall

Michigan State University Dr. Andrew D. Hunt, Jr.

University of Michigan

*Dr. John A. Gronvall

Wayne State University
*Dr. Irwin J. Schatz

Geographical Areas

East Central Area
Mr. Milton Sacks

North Central Area

Mr. Milton D. Rasmussen

Southeast Area

Mr. William S. McNary

Southwest Area

Mr. Daniel N. Finch

Upper Peninsula Area

Dr. Walter J. Wentz

West Central Area
*Dr. John C. Peirce

Public-at-Large

Dr. Ethelene J. Crockett Mr. W. Anson Hedgecock Dr. Matthew R. Kinde Mr. August Scholle (resigned 4-30-69) Mr. Phillip C. Sims (resigned 6-30-69)

Officers of the Corporation

President

Dr. Don Marshall Vice-President

Dr. John C. Peirce Secretary-Treasurer

Dr. Dorothy E. Carnegie Officers of the Regional Advisory Group

Chairman

Dr. Michael J. Brennan

Acting Vice-Chairman

Mr. W. Anson Hedgecock
Staff

Program Coordinator

Dr. Albert E. Heustis

Associate Program Coordinator

Dr. Gaetane M. Larocque
Assistant Program Coordinato

Assistant Program Coordinator
Mr. Harold R. Poindexter

Field Representative

Mr. David E. Eaton

Assistant to the Program

Coordinator

Mrs. Ilze V. Koch Professional Advisory

Councils, Chairmen

Professional Advisory Council on Cancer

Dr. Harold E. Bowman

Professional Advisory Council on Respiratory Diseases

Dr. Josef R. Smith

Professional Advisory Council on Heart Disease

Dr. Donald C. Overv

Professional Advisory Council on Stroke

Dr. Frank Cullis

Task Forces, Chairmen

Compatibility of Educational Media

Dr. Richard D. Judge Continuing Education

Dr. William H. Knisely

Incidence and Prevalence
Dr. Richard D. Remington

Methods and Evaluation

(Vacant)
MARMP wishes to acknowledge the financial support of

edge the financial support of the U.S. Department of Health, Education and Welfare. However, MARMP views expressed herein do not necessarily represent those of the Department.

Dr. Richard D. Judge

Available on Request

By-laws

The Regional and Categorical Program Plans

Guidelines for Continuing Edu-

cation Programs
Administrative Requirements
for Grant Applicants

^{*}Member of Board of Directors, which also includes Dr. William N. Hubbard, Jr.



Let's be specific about Campbell's Soups... and <u>reducing diets</u>



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to: Campbell Soup Company, Box 265, Camden, N. J. 08101

LOMOTIL SAVES...

TABLETS LIQUID

ach tablet and each 5 cc. of liquid contain diphenoxylate hydrochloride 2.5 mg (Warning: May be habit forming) atropine sulfate: 0.025 mg. (1/2.400 grain)

body fluids... electrolytes...

Lomotil acts promptly and directly to lower the excessive intestinal motility of diarrhea. This therapeutic restraint on the overactive bowel allows a normal or more nearly normal reabsorption of water and electrolytes.

patients from exhaustion

The proficiency of Lomotil in conserving body fluids and electrolytes often saves patients from the exhaustion that accompanies prolonged diarrhea. Lomotil acts to control the intestinal mechanisms of diarrhea; therefore, it is highly useful in controlling diarrhea associated with:

gastroenteritis · acute infections · functional hypermotility irritable bowel · ileostomy · drug-induced diarrhea

Warnings I omout should be used with caution in patients taking barbiturates and with caution, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions. Lomotil is a Federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur, signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary. The subtherapeutic amount of atropine sulfate is added to discourage deliberate overdosage.

Adverse Reactions. Side effects reported with Lomotil therapy include natusea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticalla, lethargy, ancrexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise. Respiratory depression and coma may occur with overdosage. Dosage. The recommended initial daily dosages, given in divided

hildren: Tulal Daily Dosage

1-6 mo ½ tsp. *1.i.d. (3 mg.)
b-12 mo ½ tsp. q.i.d. (4 mg.)
1-2 yr. ½ tsp. 5 times daily (5 mg.)

5-8 y1 tsp. q.i.d. (8 mg.)
b-12 yı ...1 tsp. 5 times daily (10 mg.)
Adult .: 2 tsp. 5 times daily (20 mg.)

«Based on 4 cc. per leaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

G. D. SEARLE & CO.
Research in the Service of Medicine





this ulcer did not heal...until its surface was cleared of dead tissue and debris



FIRST APPLICATION

ELASE Ointment is applied to a deep ulceration of a finger

EIGHTEEN DAYS LATER Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic tissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.



to aid in debridement to facilitate healing in chronic cutaneous ulcers...

Elase Ointment

(fibrinolysin and desoxyribonuclease, combined,[bovine] ointment)

By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation...for healing. Its lytic enzymes effectively break down DNA in dead leuko-cytes and other debris...the fibrin in blood clots, serum, and purulent exudates... and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively un-affected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. Precautions: Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. Adverse Reactions: Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. Discussion: Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. Available: ELASE Ointment is supplied in 30-Gm, tubes containing 30 units (Loomis) of the indicated of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg, thimerosal (mercury derivative); and in 10-Gm, tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg, thimerosal, ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package. Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS



School Problems Theme Of Second Annual **MSMS** Sex Education Workshop

(See Related Story, Page 1294)

CONCERNED REPRESENTATIVES of the Michigan Council of Churches, Michigan Congress of Parents and Teachers, Michigan State Medical Society, Michigan Departments of Public Health and Education, registered nurses and osteopaths were in attendence at the Second Annual Sex Education Workshop Oct. 18 at MSMS Headquarters.



AROUSED COMMUNITIES, alarmed at charges that their schools are teaching the wrong kind of sex education, pose problems to educators like Roger Horton, Science Consultant for the Holly Area Schools, who described his school's experiences at the workshop. Discussing the school's difficulties with Mr. Horton is, left, Richard T. Mellis, M.D., Kalamazoo, chairman of the Lay Education Subcommittee of the MSMS Maternal Health Committee, which sponsored the workshop.



GREATER COOPERATION in helping solve the problem of presenting sound, well-thought-out sex education programs in the schools was pledged by Mrs. Jane Tate, president of the Michigan Congress of Parents and Teachers, a workshop speaker, and James E. Harryman, M.D., Muskegon, chairman of the MSMS Maternal Health Committee.

BLUE-EYED Lucinda Ann Cooper of East Rockwood, Michigan's 1969 Christmas Seal Campaign Chairman, is an ambassador of goodwill telling of the important work and accomplishments being achieved through contributions to Christmas Seals. Among her duties during November and December have been trips to TB hospitals like Northlawn Hospital in Jackson, where she visited with Director George H. Phillips, M.D., and two young patients. A former tuberculosis patient herself, Lucinda is a student at Abilene Christian College in Abilene, Tex., where she is preparing to be a kindergarten teacher.



A SERIES of seven hearings is being held around the state by the Michigan Republican Party's Task Force on Health and Mental Health, one of 17 task forces currently at work to make recommendations in many fields to Republican legislators, the governor and the 1970 party platform committee. Frederick W. Van Duyne, M.D., Flint, left, health task force chairman, confers here with Allen J. Enelow, M.D., professor and chairman of the Department of Psychiatry, Michigan State University College of Human Medicine, and Donald Weston, M.D., associate professor of psychology at MSU.

PURPOSE OF the task force hearings across the state is to hear testimony from people in the field to inform task force members as to the best steps to take in recommending action to state Republican leaders. At the hearing in Lansing, Doctor Van Duyne, far left, and his committee hear the viewpoints of Doctor Enelow, third from right, regarding the mental health of juveniles.





A CHECK for \$10,000 is presented by Donald N. Sweeny, Jr., M.D., chairman of the board of trustees of the Wayne County Health Foundation, to James Woodworth, director of special projects at the University of Detroit. The funds were awarded to be used "solely for the purpose of providing funds for the 'Pre-Professional Project of the Fund for Disadvantaged Students," to be given to those minority group students who in their freshman year indicate a good faith intent to pursue a medical career.



Wayne County Health Foundation Aids Minority Group Students

THE POST-BACCALAUREATE Program for the Disadvantaged Student seeking admission to the Wayne State University Medical School, represented by Henry Maisel, M.D., chairman of the WSU School of Medicine Committee on Negro Recruitment, received \$15,000 from the Wayne County Health Foundation at a recent presentation ceremony. Doctor Sweeny again made the presentation.





THE BENEFACTORS of Wayne County Medical Foundation funds to aid minority group youths with interest in and ability to pursue a career in the health fields gathered after a recent presentation ceremony. From left are James Woodworth, director of special projects for the U. of D.; Eddie Dixon student in the WSU Post-Bac-

calaureate Program; Dolores Hill and Bennie J. Lloyd, students in the U. of D. Pre-Professional Project; Wayne Ingram, WSU student also in the Post-Baccalaureate Program, and Henry Maisel, M.D., chairman of the WSU School of Medicine Committee on Negro Recruitment.

Michigan's Gov. William G. Milliken was featured speaker at the kickoff of the 1969 Community Health Week, a state conference at The University of Michigan. Remarks from his speech on health manpower policies appear on page 1248.



Highlights Of Community Health Week



An array of Michigan's health leaders was present at the Ann Arbor kick-off to Community Health Week. Among them were, from left, Luther R. Leader, M.D., Royal Oak, executive secretary, Michigan Board of Registration in Medicine; E. Gifford Upjohn, M.D., Kalamazoo, president, Michigan Health Council; Hugh W. Brenneman, MSMS executive director; Robben Fleming, U-M president; Gov. Milliken; Edwin H. Place, M.D., president, Washtenaw County Medical Society; John W. Porter, acting Superintendent of Public Instruction; Sidney E. Chapin, chairman, public relations committee, Wayne County Medical Society; Harold F. Falls, M.D., MSMS Council member, and William N. Hubbard, Jr., M.D., director of the University Hospital and dean, U-M School of Medicine.

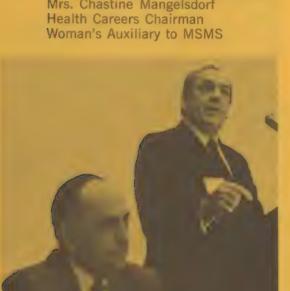


Winners of the statewide Community Health Week poster contest for youth pose with Gov. Milliken. From left are Tom McLellan, Battle Creek Lakeview High School; Rosemary Hammond, Battle Creek Pennfield High School, and Dan McLellan, Battle Creek Lakeview.

At the Ann Arbor conference, major speakers included:



Mrs. Chastine Mangelsdorf Health Careers Chairman



Hugh W. Brenneman, Executive Director Robert J. Mason, M.D., President Michigan State Medical Society



Herman Glass **Assistant Administrator** Providence Hospital



Milton Palmer, M.D. Talent Recruitment Committee Detroit Medical Society



Two local doctors were interviewed each day on Escanaba Radio Station WDBC, in a special series of hour-long programs arranged for Community Health Week. Among them were James R. Dehlin, M.D., Gladstone, center, Donald Fitch, M.D., Escanaba, right, with Al Holtein of the radio station.

Tuberculosis, Thoracic Associations Hold Joint Annual Meeting

OKLAHOMA PHYSICIAN James F. Hammarsten, M.D., left, president of the American Thoracic Society who made a presentation on "A New Idea in Continuing Education in Chest Disease," got an enthusiastic reception at the MTRDA-MTS annual meeting from Winthrop N. Davey, M.D., Ann Arbor, president of the MTRDA.



"THE 70's - Countdown to Tomorrow's Health" was the theme of the 62nd Annual Meeting of the Michigan Tuberculosis and Respiratory Disease Association and the Michigan Thoracic Society held recently in East Lansing. A highlight was the presentation by the Thoracic Society of the Bruce Douglas Award for devotion to the field of tuberculosis treatment or control. The award was presented to Cameron Haight, M.D., Ann Arbor, left, who was cited for his pioneering work in lung surgery. Making the presentation was Herbert E. Sloan, Jr., M.D., Ann Arbor, professor of surgery at the University of Michigan Medical School.





AMONG SPEAKERS at the MTRDA-MTS annual meeting were, from left, John Isbister, M.D., Lansing, chief, bureau of Community Health, Michigan Department of Public Health; Miss Phyllis Edwards, M.D., chief, Tuberculosis Program, National Communicable Disease Center, Atlanta, Ga., and Larry Drost, public health advisor, Genesee County Health Department, Flint.

SEVERAL MIDWESTERN states in addition to Michigan claim a share in the important medical research done by William Beaumont, M.D. In an accident on Mackinac Island in 1822, a young French adventurer, Alexis St. Martin, was shot in the stomach. The wound healed, leaving an open fistula like a window through which Doctor Beaumont observed the actions of the stomach in digesting. Following his series of experiments on Mackinac Island, Doctor Beaumont performed another 56 in the First Fort Crawford Military Hospital in Prairie du Chien, Wis., which the building at right replaced. Now a museum, the building was headquarters for Doctor Beaumont during 1831 and 1832, when he left in charge of wounded militia (the Black Hawk War) for Jefferson Barracks, St. Louis.



JULY 1970 is the target date for completion of the new Michigan Dental Association headquarters being constructed in Lansing's downtown urban renewal district. First shovels full of dirt were tossed at the groundbreaking last August by, from left in foreground, H. J. Walkotten, D.D.S., MDA president and former chairman of the MDA **Building Committee; Lansing Council**man Lucile Belen and Lansing Mayor Gerald Graves. The Dental Association will share its new building with professional and trade associations, and will feature an exterior of limestone and dark glass. It is one of the first to go up on the urban renewal ground.





An architect's sketch of the proposed new Michigan Dental Association Building.

HIGHLY SOPHISTICATED medical equipment, some never before displayed in public, was part of special animated displays featured in the "Century II Exhibit" staged at Providence Hospital as part of the centennial celebration. Sister Gertrude cut the ribbon to open the exhibit, which was eventually seen by 2,000 persons. Other observances included award presentations to employees and staff, a formal centennial dinner in Cobo Hall for employees and their families and a series of special seminars dealing with future developments and trends.



Providence Hospital Marks 100 Years

"DOCTORS DAY" was proclaimed as part of the Providence Hospital centennial celebration. William Briggs, M.D., medical director, was among the physicians on the staff who received lavender boutonnieres. Sister Gertrude does the honors.





"CENTURY II, The Next 100 Years," is the motto of Providence Hospital's Centennial Year, and reflects the Southfield hospital staff's concentration on the future. New Administrator Sister Gertrude Bastnagel is aiming at the completion of a "comprehensive health center" at the hospital and the extension of out-patient services. Providence Hospital is a 401-bed hospital employing 1,000 people. It was established in 1869

as a maternity hospital and home for abandoned children and made the transition to a general hospital in 1910. It is now part of the Greater Detroit Area Hospital Council Master Plan, with a new (since 1965) location at W. Nine Mile Road and Greenfield. An out-patient service for mental health patients was put into operation under a grant from the Oakland County Community Mental Health Board, in 1967.



NEWS BRIEFS

JACK L. BARRY, M.D., SAGINAW,

was elected president of the Saginaw Emergency Service corporation for St. Mary's Hospital. Other officers include Thomas Kretschmer, M.D., vice president; K. J. Forster, M.D., secretary, and V. W. Hereza, M.D., treasurer, all of Saginaw.

WELDON COOKE, M.D., BERRIEN CENTER,

medical director of the Berrien General Hospital, was appointed Berrien Springs village health officer recently by the village council.

BERRIEN COUNTY DOCTORS

have played a part in local civic meetings lately. Russell J. Vastine, M.D., Buchanan, spoke on drugs before the Harold C. Stark School PTA; Stanley Mesirow, M.D., Benton Harbor dermatologist, discussed skin care with a YMCA class of teenage girls with weight problems, and David Learned, M.D., Benton Harbor anesthesiologist, participated in a drug abuse information seminar for parents at the St. Joseph YWCA.

AMONG 12 PERSONS

appointed by Gov. William Milliken to a new State Health Facilities Council are Andrew D. Hunt, Jr., M.D., dean of the Michigan State University College of Human Medicine, and Byron P. Brown, M.D., Charlotte, director of the Barry-Eaton County Health Departments. The new council replaces an appointive group under terms of a 1968 law and serves in an advisory capacity to the State Department of Public Health in the areas of licensing and administration of hospitals.

TWO MICHIGAN PHYSICIANS

were among participants in the first Scientific Assembly of the American College of Emergency Physicians held Nov. 19-21 in Denver, Colo. They were Eugene C. Nakfoor, M.D., of St. Lawrence Hospital, Lansing, and Robert J. Rathburn, M.D., of St. Joseph Hospital, Flint.

J. C. S. BATTLEY, M.D., PORT HURON.

was honored with a testimonial dinner given recently by the Port Huron Hospital staff to mark his retirement after nearly 50 years as a pediatrician in the Blue Water District. Highlight of the dinner was a talk by George Lowrey, M.D., Ann Arbor, professor of pediatrics at the U-M, who honored the "Father of Pediatrics in Port Huron." Doctor Battley is now serving as consulting physician for St. Clair County Community College. For 20 years he was the only pediatrician in the area and it was largely through his efforts that the first pediatrics facilities at local hospitals were established. He is a past president of the St. Clair County Medical Society.

TWO LENAWEE COUNTY

physicians, Howard Eddy, M.D., and Xenophon Skufis, M.D., of Adrian, participated in a dialogue about drugs during assemblies at Adrian High School in October. Doctor Eddy concentrated on the medical dangers of LSD and marijuana and Doctor Skufis on amphetamines, barbiturates and heroin.

JAMES FEENEY, M.D., ADRIAN,

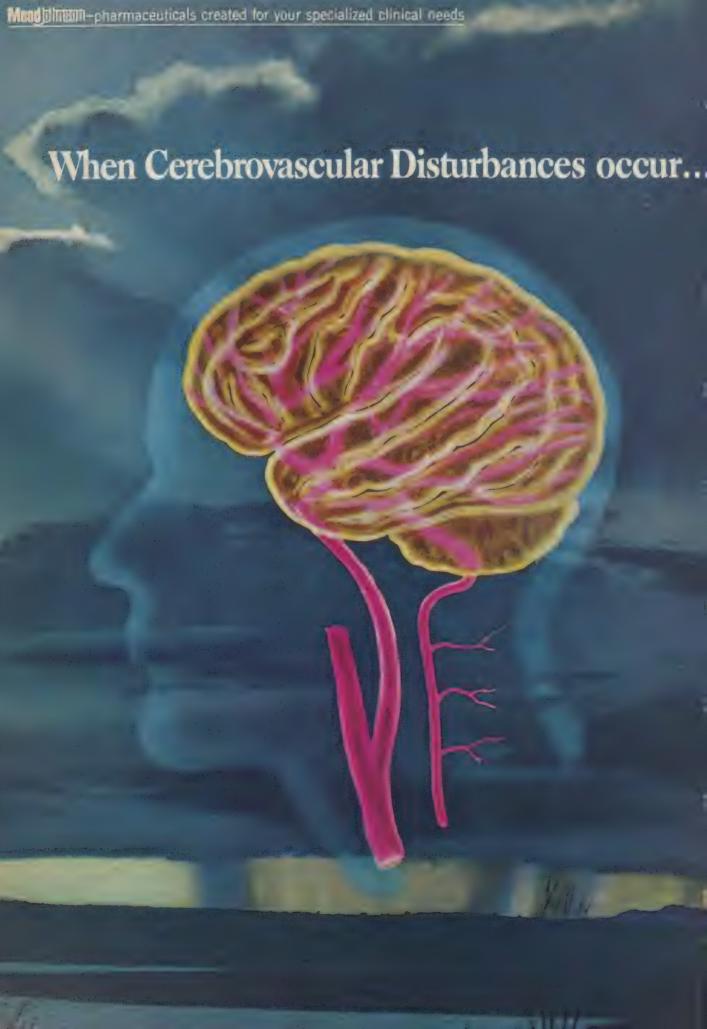
chairman of the Lenawee County Medical Society Coronary Care Committee, assisted by the director of the Adrian Bixby Hospital Coronary Care Unit, designed and led a two-week intensive course in coronary care for cardiac technicians. On the staff of the seminar were other physicians from the Bixby Hospital staff, who are adding their efforts to help staff the hospital's coronary care unit with cardiac technicians.

Dr. Pollard Selected As Cover Subject By MODERN MEDICINE

Another Michigan doctor has been made the subject of the cover feature by the editors of Modern Medicine.

Cover subject for the Oct. 20 issue of the national medical magazine was H. Marvin Pollard, M.D., professor of internal medicine and head of the University of Michigan gastroenterology section. Sibley W. Hoobler, M.D., also U-M professor of internal medicine, and director of the university Hospital's Hypertension Unit, was featured in the July 14 issue.

One of the nation's foremost internists and gastroenterologists, Doctor Pollard is immediate past president of the American College of Physicians, was president of the American Gastroenterological Association during 1959-60 and is treasurer of the World Organization of Gastroenterology and a director-at-large of the American Cancer Society.



...with episodes of vertigo, headache, confusion, sensory loss, slurred speech, consider

VASODILAN® (ISOXSUPRINE HCI)

to help relieve symptoms by preventing vasospasm and increasing cerebral blood flow



Although not all clinicians agree on the value of vasodilators in vascular disease,¹ several investigators²-5 have reported favorably on the effects of isoxsuprine on cerebral blood flow. Effects have been demonstrated both by objective measurement²-5 and observation of clinical improvement.²-4 Indications: Cerebrovascular insufficency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). Composition: VASODĪLAN tablets, isoxsuprine hydrochloride 10 mg. Dosage: Oral—10 to 20 mg. (1 or 2 tablets) t.i.d. or q.i.d. Contraindications and Cautions: There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. Side Effects: Occasional palpitation and dizziness can usually be controlled by dosage reduction. As intramuscular administration of 10 mg. or more may cause brief hypotension and tachycardia, single intramuscular doses exceeding this amount are not recommended. Complete details available in product brochure from Mead Johnson Laboratories References: (1) Fazekas, J. F.; Alman, R. W.; Ticktin, H. E.; Ehrmantraut, W. R., and Savarese, C. J.: Angiology 15:No. 2 (Feb.) 1964. (2) Horton, G. E., and Johnson, P. C., Jr.: Angiology 15:70-74 (Feb.) 1964. (3) Clarkson, I. S., and LePere, D. M. Angiology 15:82-87 (Feb.) 1964.

NEW FLINT SCHOOL NAMED FOR DR. WILLIAMS OFFERS UNUSUAL SERVICES

The new T. Wendell Williams school in Flint, named for the Flint doctor who was the first Negro to serve on the Flint Board of Education, was opened to its young pupils with the first days of school in September.

The late Doctor Williams died in January, 1967 and his position was filled by Clarence B. Kimbrough, M.D., who subsequently became the first Negro to serve as president of the board of education, a position he held from July, 1968 to July, 1969.

The design and functions of the new Williams School, which adjoins a 72-acre park, stress the board's desire to have citizens from different races interact with each other, study, play and work on projects together that will be for the good of everyone.

Its extensive facilities include a roofed, heated swimming pool, an ice rink, a community area housing welfare, mental and physical health services, Michigan Employment Securities Commission facilities, a workshop area for home repair education and a communication area for audio-visual and language arts instruction, photography, arts and library services, and the computer education terminal.

NEW OFFICERS

of the Oakland County Medical Society include James R. Quinn, Jr., M.D., Bloomfield Hills, president-elect; John H. McLaughlin, M.D., Birmingham, secretary, and Dale R. Drew, M.D., Pontiac, treasurer.

FRANKLIN DAVID JOHNSTON, M.D., ANN ARBOR.

received the American Heart Association's 1969 James B. Herrick Award in ceremonies Nov. 14 at the association's annual meeting in Dallas. The award, consisting of a medallion and citation, was presented to Doctor Johnston for "outstanding achievement in the advancement and practice of clinical cardiology." Doctor Johnston is a developer of new techniques in the use of the electrocardiograph.

GEORGE J. HOEKSTRA, M.D., KALAMAZOO,

is new president of the North Christian School Association in Kalamazoo.

FRANK M. STEELE, M.D., KALAMAZOO,

is chairman of the medical explorers post meeting every two weeks at Borgess Hospital for the purpose of giving young men and women a chance to become familiar with careers in the health field.

H. SIDNEY HEERSMA, M.D., KALAMAZOO,

is president of McKercher's Rehabilitation Center, Inc., Kalamazoo, which provides rehabilitation, training and placement for mentally retarded persons. He also was re-elected regional vice president of the Michigan Association for Retarded Children, a position which he serves by coordinating programs between the state organization and local associations for retarded children in Allegan, Barry, Van Buren, Calhoun, Berrien, Cass, St. Joseph, Branch and Kalamazoo Counties.

ARTHUR D. ERICSSON, M.D., FORMERLY OF DETROIT,

has moved to Houston to continue his work in association with John Stirling Meyer, M.D. Both were with Wayne State University and have joined the Baylor College of Medicine and Texas Medical Center. Doctor Ericsson is continuing his study of cerebral metabolism in neurological disorders.

ROBERT C. ANTLE, M.D., BAY CITY,

copped championship honors for the third consecutive year in the DDD Day Golf Tournament at the Bay City Country Club. Doctor Antle also won the three blind hold event, while Edward Rodda, M.D., took low gross honors. Doctor Rodda received a special prize for making a hole-in-one earlier in the season.

EDWIN TERWILLIGER, M.D., SOUTH HAVEN,

received a certificate of appreciation from the South Haven Community Hospital board at ceremonies recently prior to the doctor's moving to Florida. Doctor Terwilliger has been a practicing physician in South Haven since 1936 and associated with the hospital board for eight years. He retired in 1967 from active practice and plans to move to Bradenton, Fla., where he and Mrs. Terwilliger will take up permanent residence.

KAMRAN S. MOGHISSI, M.D., DETROIT,

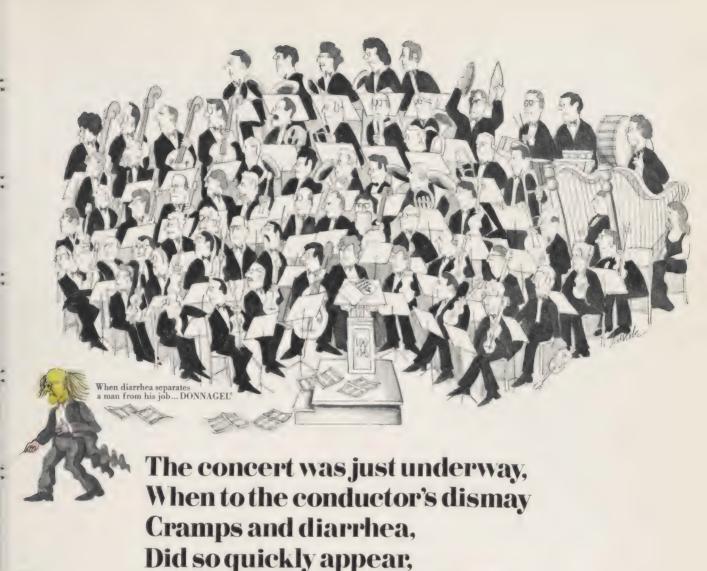
was one of four featured speakers at the 12th annual clinic day at St. Joseph Mercy Hospital in Pontiac Nov. 12. Doctor Moghissi discussed "Immunological Factors in Reproduction."

JULIEN PRIVER, M.D., DETROIT,

has been named new president-elect of the Michigan Hospital Association. He was chosen at a recent convention at Mackinac Island by the MHA House of Delegates.

BRUCE PROCTOR, M.D., DETROIT,

is a member of the faculty for the first international Winter Medical-Dental Assembly scheduled Feb. 14-Feb. 28 in Norway. He will discuss the "Present State of Tympanoplasty."



The maestro no longer could stay.

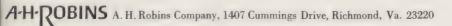
Because diarrhea with cramping, nausea, and painful straining can strike at the most inopportune time, it takes a comprehensive agent to treat the total diarrheal syndrome and help get the patient back on the job. That's why so many physicians rely on Donnagel, especially during the fall and winter months when "flu" and viral gastroenteritis usually hit their peak.

Donnagel is much more than just a simple kaolin-pectin combination. It also contains the belladonna alkaloids to calm GI hypermotility and help relieve the distressing discomforts which so often accompany diarrhea. Certainly it's less expensive and more convenient than taking two medications. And the dosage is lower too. Available in the handy 4-oz. plastic bottle at pharmacies everywhere on your prescription or recommendation.

For Diarrhea and its Discomforts

Donnagel

Each fluid ounce contains: Kaolin, 6 Gm.; Pectin, 142.8 mg.; Hyoscyamine sulfate, 0.1037 mg.; Atropine sulfate, 0.0194 mg.; Hyoscine hydrobromide, 0.0065 mg.; Sodium benzoate (preservative), 60 mg.; Alcohol, 3.8%.







CILIAR THERE'S A ROBITUSSIN FOR EVERY COUGHING NEED TRACTOR

All the Robitussins contain gylceryl guaiacolate, an outstanding expectorant agent that greatly increases the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheobronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"
ROBITUSSIN®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Alcohol, 3.5%

Non-narcotic for 6-8 hr: cough control
ROBITUSSIN-DM®
Each 5 cc. contains:
Glyceryl guaiacolate ... 100.0 mg.
Dextromethorphan
hydrobromide ... 15.0 mg.
Alcohol, 1.4%

For unproductive allergic coughs
ROBITUSSIN A-C®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Pheniramine maleate . . 7.5 mg.
Codeine phosphate . . . 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Clears sinuses and nasal stuffiness as it relieves cough ROBITUSSIN-PE® Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg. Phenylephrine hydrochloride 10.0 mg. Alcohol, 1.4%

Robitussin-DM in solid form for "coughs on the go" COUGH CALMERSTM Each Cough Calmer contains:
Glyceryl guaiacolate . . 50.0 mg.
Dextromethorphan hydrobromide . . . 7.5 mg.

Use this handy guide to pick the right formulation for each coughing need

	Robitussin	Robitussin-DM	Robitussin A-C	Robitussin-PE	Cough Calmers
Expectorant	•	•	•	•	•
Demulcent	•	•	•	•	•
Cough Suppressant		•	•		•
Antihistamine			•		
Long-Acting (6-8 hours)		•			•
Nasal, Sinus Decongestant				•	
Non-narcotic	•	•		•	•



Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!

Optimal neutralization—provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste—confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.¹

Concomitant relief of G. I. gas distress—provided by the proven antiflatulent action of simethicone.²

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonfuls to be taken between meals and at bedtime, or as directed by physician.

References: 1. Danhof, I. E.: Report on file. 2. Hoon, J. R.: Arch. Surg. 93:467 (Sept.) 1966.

Mylanta Mylanta

aluminum and magnesium hydroxides <u>plus</u> simethicone



Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109



GOVERNMENTAL-MEDICAL CARE PROGRAMS

MICHIGAN COMPREHENSIVE HEALTH PLANNING

The Advisory Council was requested by the Commission to develop recommendations to encourage funding patterns to support area-wide planning agencies. The following questions were considered:

- 1. Alternatives to Federal grants, if funding is not available for all agencies.
- 2. Methods of financing agencies in areas with limited resources.
- 3. The extent to which stable sources of support can be developed.

Agencies presently under development are being funded from the following sources:

- 1. Federal Grants (50%)
- 2. United Foundation
- 3. Foundation Grants (short-term)
- 4. Public funds boards of supervisors
- 5. Public funds county health departments
- 6. Hospital contributions
- Contributions from medical and other professional societies.
- 8. Contributions from industry, banks, civil and labor groups.

The above sources are considered as seed money and not available on a continuing basis.

For comparison, Ohio support of area-wide planning agencies ranges from \$.13 to \$.36 per capita—averaging \$.22. In Michigan, current existing

applications (Battle Creek-Kalamazoo, Detroit, Grand Rapids and Lansing) range from \$.09 to \$.30 per capita — averaging \$.16. If each area in Michigan has operational planning agencies, it is estimated that \$1,500,000 would be required from all sources.*

Principles For Financing Planning Agencies:

- 1. Should have stable on-going base of support to divert staff from concentrating on fund raising.
- 2. Should be financed in a manner that will not imply direct or indirect influence over the planning process or planning recommendations.
- 3. Provisions for financing must assure the development and operation of planning agencies throughout Michigan due to the statewide implications of health problems and the unequal resources between areas.
- 4. Public as well as private sources are required to retain partnership concept.
- 5. The least acceptable methods of financing are those which place the burden on persons already ill and increase the cost of hospital prepayment and insurance.

Recommendations

- 1. For the short run to get an agency organized and operating, broad based community support should be sought from a variety of sources in such a way that no single element dominates. If funding from health providers is accepted, then contributions should be sought from all organized elements of the health field and should be obtained from county, district, or State organizations through the dues structure rather than through contributions from individual providers.
- 2. For the long run every effort should be made to obtain funding from governmental sources and from quasi-public agencies such as the United Fund and philanthropic organizations. If funds are sought from private individuals and organizations, careful and conscientious efforts must be made to avoid any conflict of interest, however subtle it might be.
- 3. In order to obtain pooling of resources for adequate financing in all areas of the State, additional support should be obtained from Michigan United Fund, in those areas in which United Fund mechanisms are non-existent or inadequate, and from State grants.
- 4. State grants should be utilized if Federal funds are not sufficient to support 50% of

^{*} Based on minimum operational budget of approximately \$100,000.

the cost of comprehensive health planning agencies in all areas. (The Advisory Council recommended that the Commission pursue all means possible to provide sources of money for State grants to support areawide and state comprehensive health planning on a continuing basis.)

Financing of Areawide Comprehensive Health Planning Agencies

	1966 Population	Total Budget	Per Capita Cost
Existing Designated Agen	cies		
Battle Creek-Kalamazoo	438,600		
1st year		\$ 76,900	\$.174
2nd year		120,500	.274
Detroit	4,559,500	,	
1st year	, ,	414,090	.090
2nd year		(419,808)	(.092)
Grand Rapids	660,400		, ,
1st year	,	92,936	.140
2nd year		101,790	.154
Lansing	339,500	,	
1st year		56,991	.168
2nd year		105,076	.309
Potential Agencies			
Berrien-Cass-VanBuren	253,700		
Flint	537,700		
Jackson	255,900		
Muskegon	191,300		
Saginaw	624,400		
Traverse City-Alpena	228,500		
Upper Peninsula	298,500		

(Source: Office of Comprehensive Health Planning)

The Advisory Council appointed by the Governor to advise the Commission, recommended that reduction of infant mortality be a prime goal in Michigan's health needs. Other recommendations were: (1) Better nutrition among infants and children. (2) Improve care for the aged. (3) Reduce environmental pollution and urban blight. (4) Lower disease incidents. (5) Increase physical and mental health among children and youth.

* * *

There was also discussion about franchising or licensing of health care institutions with The Council in substantial agreement that constraints were needed. There was no agreement on who would be the constrainer.

STATE HEALTH FACILITIES COUNCIL

The 12-member council, created under a 1968 law, is to advise the Director of the Department of Public Health regarding both the licensing and administration of hospitals under the federal Hill-Burton Program.

HOSPITAL MEDICARE STAY

Patients may find themselves out of the hospital sooner because of a Medicare change. Effective January 1, 1970, physicians will have to certify medical necessity of hospitalization on the twelfth instead of the fourteenth day and make

recertification on the eighteenth instead of the twenty-first day. The Social Security Administration says that Medicare could save \$400 million with a one-day cut. Noting that number of discharges arises on the fourteenth and the twenty-first days and that there "is no apparent medical reason" for these peaks, SSA concludes that the requirement itself stimulates them.

MEDICARE

A recent release from the Detroit Office of Social Security emphasizes the need to better understand extended care benefits under Medicare. Extended care benefits are part of Medicare on the hospital coverage and provides payment for post-hospital in an extended care facility that is a specially equipped skilled nursing home participating in the program. The term "extended" refers not to provision of care over extended period of time, but to provision of active treatment as an extension of in-patient hospital care. The goal of ECF care is to relieve the burden on hospitals and also to transfer patients in less expensive facilities at the earliest possible time. Transfer to ECF occurs when a patient may still need skilled nursing care on a continuing basis but does not require the constant availability of medical services ordinarily found in hospitals. It should be pointed out that services are not automatically covered by Medicare when a patient enters an extended care facility but would be if the following five requirements are met:

- 1. Medical needs of the patient require continuing skilled nursing care.
- 2. Physicians determine if the patient needs extended care and if so orders.
- 3. Patients must have been in a participating or otherwise fully qualified hospital for at least three consecutive days.
- 4. Patient must be transferred to a nursing home within fourteen days after leaving the hospital.
- 5. Patient must be admitted for further treatment of the condition for which he was treated in the hospital.

The need for skilled nursing care is periodically reviewed by the attending doctor, the Utilization Review committee of doctors and professional care personnel and by the intermediary that pays the claim. If and when the patient's condition no longer requires this skilled care the Medicare benefits will cease.

MICHIGAN ECONOMIC OPPORTUNITY OFFICE

Governor Milliken recently announced the appointment of Alton M. Shipstead to be Director. Mr. Shipstead has been on the staff since July, 1969 – first, as Executive Associate and for the past two and one-half years as Deputy Director.



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least nine specific differences in-

volving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.





Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort... and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic /antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also,

at the same time, helps to control hypersecretion and hypermotility, thus reliev-

ing spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete prod-

uct information, a summary of which follows. INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign blad-der neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium

WARNINGS: Caution patients about possible

combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

PRECAUTIONS: In elderly and debilitated. limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and toler-



ated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

ADVERSE REACTIONS: No side effects or manifestations not seen with either compound

ADVERSE REACTIONS: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These

are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

two good reasons for prescribing LIRRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.



Division of Hoffmann-La Roche Inc. Nutley, New Jersey 07110



lerramycin[®] (oxytetracycline)

An infection of rapid onset requiring prompt attention. Teenage girl with chills, fever, abdominal pain, backache and nausea. Frequent and urgent urination with burning. On examination—tenderness over kidney. Blood count and urinalysis confirm the diagnosis: acute pyelonephritis. Treatment is initiated with Terramycin. Within a few days of followup therapy, the patient is markedly improved. The pretreatment urine culture shows a strain of E. coli highly susceptible to Terramycin.

Experience has shown that Terramycin offers special advantages in treating urinary tract infections when strains of causative bacteria are susceptible. Broad-spectrum coverage unaffected by penicillinase. Effective tissue levels to help reach foci of infection in renal parenchyma. High urine levels—excreted by kidney in active form.

With Terramycin, you have the assurance that comes with choosing an agent physicians have depended on for over 18 years. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Contraindicated: In individuals hypersensitive to oxytetra-

Warnings: Reduce usual oral dosage and consider antibiotic serum level determinations in patients with impaired renal

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual shorttreatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight; if such reactions occur, discontinue therapy.

Note: With oxytetracycline, phototoxicity is unknown and photoallergy very rare.

Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy. Increased intracranial pressure in infants is a possibility. Symptoms disappear upon discontinuation of

Adverse Reactions: Nausea, diarrhea, glossitis, stomatitis, proctitis, vaginitis and dermatitis, as well as reactions of an allergic nature, may occur but are rare.

Supply:* Terramycin Capsules: oxytetracycline HCl, 250 mg. and 125 mg. Terramycin Syrup: calcium oxytetracycline, 125 mg. per 5 cc. Terramycin Pediatric Drops: calcium oxytetracycline, 100 mg. per cc.

*All potencies listed are in terms of the standard, oxytetracycline.

More detailed professional information available on request.

Jerramy (oxytetracycline)



Michigan Doctors Advising Clergy Giving New Problem Pregnancy Counseling

Michigan doctors in six cities around the state have become active as advisors to local centers of the new Michigan Clergy for Problem Pregnancy Counseling, (MCP-PC), with headquarters in Detroit.

50 clergymen than More throughout the state, from 10 denominations, had affiliated themselves with the MCPPC within two weeks of its incorporation in late September, to provide individual counseling to women with personal or family sexuality prob-

Local centers are operating in Ann Arbor, Detroit, Flint, Grand Rapids, Lansing and Saginaw. Physicians serve on their advisory boards, to help keep the service at a high professional level.

By merely dialing a local telephone number available 24 hours of the day, a woman seeking counseling can obtain a tape-recorded listing of clergymen willing to talk

with her, and their telephone numbers. She is directed to call one of them, identify her problem and make an appointment for a regular counseling session.

Clergymen, after specialized training that will be continued on a regular basis, offer counseling for personal or family sexual problems; help in getting information, education or services for birth control, and help in obtaining a doctor for pregnancy testing, as well as specific counseling for the woman with an unwanted pregnancy.

The ministers do not suggest abortion to the woman with an unwanted pregnancy, but instead discuss all the alternatives the pregnant woman has, then allow her to make the decision. The clergymen hope to avoid the alternative of suicide with their new free service.

Should a woman decide on abor-

tion, the clergy counsel can assist her in obtaining a legal therapeutic abortion here, or suggest arrangements for her to have an abortion performed in a foreign country. Before one of the clergyman-counselors will discuss a problem pregnancy with a client, a certificate verifying pregnancy is required from the physician. As part of their individual counseling, clergy members specifically advise pregnant women against having illegal abortions in this country.

The final individual counseling service offered is post-termination counseling for the woman who has had an abortion.

In addition to providing individual counseling, the clergy group has pledged to seek abortion-law reform, or preferably abolition of abortion restrictions in the state's criminal code. All counseling is done confidentially and minors can be counseled with or without their parents.

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

Statement required by the Act of October 23, 1962; Section 4369, Title 39 of the United States Code showing the Ownership, Management and Circulation of Michigan Medicine, published Semi-monthly, Tri-monthly in November and December, 26 issues, mailed at East Lansing, Michigan in Ingham County for December 1, 1969.

- 1. The office of the publisher is located at 120 West Saginaw Street, East Lansing, Michigan 48823.
- 2. The general business office of the publisher is located at 120 West Saginaw Street, East Lansing, Michigan 48823.
- 3. The publisher is the Michigan State Medical Society. The Scientific Editor is John W. Moses, M.D., Mt. Carmel Mercy Hospital, Detroit, Michigan 48235; The Managing Editor is Judith Marr, 120 West Saginaw Street, East Lansing, Michigan 48823; The Executive Editor is Herbert A. Auer, 120 West Saginaw Street, East Lansing, Michigan 48823.
- 4. The owner is the Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.
- 5. The known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages, or other securities are: None.
- 6. A. The total number of copies printed averages 8,098 per issue with a single issue nearest to filing date accounting for 8,120 copies.
 - B. Paid circulation:
 - 7,121 subscriptions by mail, these being the active members of the Michigan State Medical Society who receive subscriptions.
 - C. Sales to dealers, number none.
 - D. Free distribution by mail carrier or other means: 618.
 - E. Total number of copies distributed is 7,739.

I certify that the statements made by me above are correct and complete.

Wellman Press, Inc. For the Publisher

in the treatment of

Forty cases reported. Cites synergism between androgen and thyroid.

No side effects in patients treated.
Alleviation of fatigue noted

Effectiveness confirmed by another double blind study*

1.SUMMARY ANDROID

GOOD TO EXCELLENT 75%

PLACEBO

20%

*"Sexual impotence treatment with methyl testosterone - thyroid (ANDROID) a double blind study" - Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths Android Android-HP

Each yellow tablet contains: Each red tablet contains: Methyl Testosterone . 2.5 mg.
Thyroid Ext. (1/6 gr.) . 10 mg.
Glutamic Acid . . . 50 mg.
Thiamine HCL . . . 10 mg.

Available: Bottles of 100, 500, 1000.

Methyl Testosterone . . 5.0 mg.
Thyroid Ext. (½ gr.) . . . 30 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg. Dose: 1 tablet 3 times daily. Dose: 1 tablet 3 times daily. Dose: 1 or 2 tablets daily. Available: Bottles of 100, 500, 1000.

Write for literature and samples:

THE BROWN PHARMACEUTICAL CO. 2500 W. 6th St., Los Angeles, Calif. 90057

Android-X

EXTRA HIGH POTENCY

Each orange tablet contains: Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.)64 mg.
Glutamic Acid50 mg.
Thiamine HCL10 mg. Available: Bottles of 60, 500.



Android-Plus

chemotherapy

cannot be disputed.

WITH HIGH POTENCY B-COMPLEX AND VITAMIN C Each white tablet contains:
 Methyl Testosterone
 2.5 mg.

 Thyroid Ext. (½ gr.)
 1.5 mg.

 Ascorbic Acid (Vit. C)
 250 mg.

 Thiamine HCL
 25 mg.

 Glutamic Acid
 100 mg.

 Pyridoxine HCL
 5 mg.

 Niacinamide
 75 mg.

 Calcium Pantothenate
 10 mg.

 Vitamin B-12
 2.5 mg.

 Riboflavin
 5 mg.
 Methyl Testosterone . . 2.5 mg. Dose: 2 tablet twice daily.

Available: Bottles of 60, 500.

6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of also available with ESTROGEN

Android-E

Each Tablet Contains: Each Tablet Contains:
Methyl Testosterone 2.5 mg.
Ethinyl Estradiol 0.02 mg.
Thyroid Ext. (1/6 gr.) 10 mg.
Thiamine Hydrochloride 10 mg.
Glutamic Acid 50 mg.

NUTAMIC ACIDA S. Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis: 005E: One tablet t.id. Female patients should have a rest period 5 to 7 days after 21 days of medication. SIBE EFFECTS: In the of medication. SIDE EFFECTS: In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsulism, enlarged ciltoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. CONTRA-INDICATIONS: See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

INGRAM'S SERVICE DEPARTMENT

ALL FACTORY TRAINED MEN

We service Medical Equipment, Electrocardiographs, Basal Metabalors, Sterilizers, Autoclaves, Diathermy Outfits, Cutting Units, Ultra Violet Lamps, Hydro Therapy Units, Laboratory Equipment. ALL BURDICK, LIEBEL FLARSHEIM AND RITTER EQUIPMENT.

If you have any Service problems, please call us at TE 2-4444, ask for the SERVICE DEPARTMENT and we will gladly help in any way we can.

THE G. A. INGRAM COMPANY

4444 Woodward Avenue

TEmple 2-4444

Detroit, Michigan 48201

Sex Education Workshop Participants Pledge Greater Cooperation

BY JUDITH MARR MANAGING EDITOR

Greater cooperation between physicians, educators and the clergy was pledged by representatives of all three professions who attended the second annual Sex Education Workshop at MSMS headquarters Oct. 23.

They gathered to hear reports from representatives of Michigan school districts which have been confronted with local controversy over sex education programs in their public schools.

"We hope to learn something from their experiences to help the communities solve their problems," said Richard T. Mellis, M.D., Kalamazoo, chairman of the sponsoring lay education subcommittee of the MSMS Maternal Health Committee.

Participating in the workshop were leaders of the Michigan Youth Commission, Michigan Congress of Parents and Teachers, Michigan Council of Churches, the Michigan Departments of Education and Public Health, and individual physicians, osteopaths and registered nurses.

Teachers and administrators from Livonia, Walled Lake, Holly and Flint's Kearsley school systems described recent community outbreaks over family life and sex education programs.

In each case, following the community uproar, the schools have diminished their sex education programs or at least decided against any further expansion of them for several years, they reported.

Daniel Eskins of the Department of Special Education, Kearsley Community Schools, Flint, struck a general note of agreement between seminar participants when he said that "no parents, congregation or community can decide against sex education. The question is not whether to have sex education, but what kind.

"Education and medicine are very much aware that youngsters know what's going on," he continued. "It's just a question of how we are going to give them the assistance they want. They ask honest questions and they expect honest answers."

Another key point made was the importance of putting into law state-wide guidelines for the teaching of family life and sex education in the public schools. Most Michigan schools, revealed the educators present, are currently waiting for such guidelines before proceeding further with any such programs.

An advisory committee set up by the State Board of Education to establish such guidelines has run into vociferous, emotional and even threatening opposition in a series of nine local hearings across the state. The committee's guideline-writing subcommittee chairman, Eleanor Skufis, M.D., Adrian, was present at the seminar and gave a brief account of the advisory committee's work and problems.

Ray O. Creager, M.D., director of the Kalamazoo Child Guidance Clinic, discussed appropriate levels for teaching various aspects of sex education to children, and a representative of the state department of education provided a brief history of the outlook of state government on sex education as reflected in the laws.

The seminar was concluded with a response by Mrs. Jane Tate of Detroit, president of the Michigan Congress of Parents and Teachers.

Mrs. Tate observed that the state-wide PTA organization has for many years stressed the need for sex education.

"We believe the home is the basic unit for such instruction and the most constructive for building a child's values," she said. "But far too many parents need on-the-job training."

(See Related Pictures, Page 1269)

"The children with good sex education at home have nothing to lose," she said. "But those who don't, have much to gain."

Those among the opposition to sex education in the schools she categorized as 1) those who genuinely question the methods and the subject matter, 2) those using the controversy for political reasons and 3) those of the radical right who use the Communist label for their opposition, who employ all the extremist tactics and exploit apathy.

Demand proof, demand their identification and expose their "humble parent-from-the-heart" tactics to thwart the latter, she counseled.

She suggested that members of the medical profesion 1) have the responsibility to speak out on the issue and "not permit amateurs to co-opt the debate," 2) should do some homework about their communities and then use their medical expertise to participate in the debate and 3) may participate in the discussion as private citizens.





Appearances may be deceiving



It may be tetracycline but it's not ACHROMYCIN V Tetracycline HCI unless it bears this signature.



250 mg. and 100 mg. capsules

Contraindications: Hypersensitivity to tetracyclines. Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs. Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Side Effects: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. Kidney—dose-related rise in BUN. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Intracranial—bulging fontanels in young infants. Teeth—yellow-brown staining; enamel hypoplasia. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.





symptoms of mixed anxiety-depression are rarely clear-cut...
but they are often a clear indication for

Mellaril* (thioridazine) 25 mg. t.i.d.

effective in mixed anxiety-depression and in moderate to severe anxiety

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: Central Nervous System—
Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. Autonomic Nervous System—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. Endocrine System—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. Skin—Dermatitis and skin eruptions of the urticarial type, photosensitivity. Cardiovascular System—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. Other—A single case described as parotid swelling.

SANDOZ PHARMACEUTICALS, HANOVER, N.J. SANDOZ 69-384

Community Health Week Observances Took Many Forms Across State

Michigan's 1969 Community Health Week — with the focus on health careers promotion — was observed in a variety of ways across the state.

Key observances of the Oct. 19-25 event included the 1969 Community Health Week State Conference Monday, Oct. 20, at Towsley Center for Continuing Medical Education, the University of

(See Related Pictures, Pages 1272-1273)

Michigan, Ann Arbor; a day-long "Health Manpower for Southeastern Michigan" program at Providence Hospital, Southfield, to introduce high school guidance counselors to health leaders from across the state. A similar Western Michigan Counselor Workshop on Health Careers for Students was scheduled before Community Health Week on Oct. 8 in Grand Haven.

In Escanaba, radio station WDBC gave an hour's air time between 9 and 10 a.m. every day of the week to interviews on various health topics with two or more doctors.

In Battle Creek, the Calhoun County Medical Society, its auxiliary, the Calhoun County Pharmaceutical Association and the Calhoun County Health Department sponsored a Health Careers Carnival at St. Philips High School, attended by students from all the high schools in the county.

In Detroit, John A. Doherty, executive director of the Michigan Health Council, co-sponsor of Community Health Week with MSMS and the Michigan Association of the Professions, appeared with James D. Fryfogle, M.D., president of the Wayne County Medical Society, on WXYZ-TV's Morning Show Monday morning.

Detroit Radio Station WJLB's Martha Jean interviewed Charles C. Vincent, M.D., of the Wayne County Medical Society, and Martin Luther King High School Health Careers Club members Freda Crumpton and Veda Page.

Showings of the AMA film, "Horizons Unlimited" were arranged throughout the city during the week at a number of area high schools and guidance counselors discussed the variety of health careers at related assemblies.

Tours of Grace Hospital were taken by Detroit's Kettering Senior High and Webber Junior High School students and arrangements were made for George Pickett, M.D., Detroit and Wayne County Health Commissioner, to appear on the J. P. McCarthy Focus program on Radio Station WJR.

During the entire week, spot announcements were made on radio and television and the Detroit Edison Company and Burton Abstract Company expressway signs featured flash-on announcements of Michigan Health Week.

In Ann Arbor all voluntary health organizations held open houses, all seven local radio stations carried spot announcements, both daily papers gave coverage and Marvin Esch, local congressman, devoted his column in the weekly papers of his district to a feature on Community Health Week.

In addition, a speakers' bureau was provided for all luncheon clubs, with Edwin H. Place, M.D., the featured speaker; a feature story about Community Health Week was made available to all 10 county papers; Mayor Robert J. Harris officially declared Community Health Week, promotional letters were sent to 200 community leaders and a packet of materials on health career recruitment was sent to all school counselors.

In many other cities across Michigan's upper and lower peninsulas, elementary, junior and senior high school students participated in local, area and state poster contests built around the theme of promoting health careers.

PLAINWELL SANITARIUM, INC.

Plainwell, Michigan - MU 5-8441

M. Leroy Barry, M.D.

Dan W. Everett, M.D. Wilbur R. King, Ph.D.

The Plainwell Sanitarium is a private psychiatric hospital licensed by the Michigan Department of Mental Health, and member of the American Hospital Association, Michigan Hospital Association, and National Association of Private Psychiatric Hospitals. Our extensive diagnostic treatment services include the following:

- Organic and psychological therapy for the psychiatrically and emotionally disturbed of all ages.
- Diagnostic evaluation of neurological disorders.
- Rehabilitative services for geriatric and convalescent patients.
- Medico-Legal counsel.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for Probate and Juvenile Courts.

when your patients need continuous potassium supplementation...



offer the unique choice of tangy lime, delicious orange

CIVIE OF THE REPORT OF THE REP

each effervescent tablet contains 2.5 Gm. potassium bicarbonate (25 mEq. elemental potassium), 2.1 Gm. citric acid, and cyclamic acid

sparkling, effervescent

With its two citrus flavors, K-Lyte offers really *special* taste appeal to assure long-term acceptance... patients will take the K-Lyte you prescribe.

Patients like the special convenience of K-Lyte. Each effervescent tablet dissolves quickly and completely in 3 to 4 ounces of cold water. Just two tablets daily provide 50 mEq. of elemental potassium to help prevent or correct potassium deficiency. K-Lyte is absorbed rapidly—and avoids any potential hazards of potassium chloride tablets.

to guide you in prescribing K-Lyte:

Composition: Each tablet contains potassium bicarbonate (2.5 Gm.), citric acid (2.1 Gm.), cyclamic acid, artificial flavor and color. Contraindications: When renal function is impaired, or if the patient has Addison's disease, potassium supplementation should not ordinarily be instituted. Precautions: Should not be used in patients

with low urinary output unless under the supervision of a physician. In established hypokalemia, attention should be directed toward correction of frequently associated hypochloremic alkalosis and other potential electrolyte disturbances. Patients should be directed to dissolve tablet in stated amount of water to assure against gastrointestinal injury associated with the oral ingestion of concentrated potassium salt preparations. Side Effects: While nausea has been reported in an occasional patient, K-Lyte produces no serious side effects when given in recommended doses to patients with normal renal function and urinary output. Potassium intoxication causes listlessness, mental confusion, tingling of the extremities and other symptoms associated with a high concentration of potassium in the serum. Administration and Dosage: K-Lyte effervescent tablets must be dissolved in 3 to 4 ounces of water before taking. Adults: 1 tablet 2 to 4 times daily, depending on the requirements of the patient. Two tablets (50 mEq. of elemental potassium) supply the approximate normal adult daily requirement. How Supplied: Effervescent tablets – boxes of 30 (orange or lime).

© 1969 MEAD JOHNSON & COMPANY . EVANSVILLE, INDIANA 47721



Specialized Service

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

MEDICAR PROTECTIVE COMPANY

FORT WAYNE INDIANA

Professional Protection Exclusively since 1899

DETROIT OFFICE: G. A. Triplett, R. K. Wind and J. K. Galloway, Representatives 27200 Lahser Road, Southfield 48075 Telephone: (Area Code 313) Elgin 3-4848 or 444-1439

GRAND RAPIDS OFFICE: G. J. Haworth, Representative 422 Federal Square Building, Grand Rapids 49502 Telephone: 616-454-4477

Established 1924

MERCYWOOD HOSPITAL

4038 Jackson Road

Conducted by Sisters of Mercy Ann Arbor, Michigan

Telephone — 313 663-8571



Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

Accredited by the Joint Commission on Accreditation of Hospitals and the National League of Nursing. A full Blue Cross participating hospital.

Certified for: Medicare and M.A.A. programs

PSYCHIATRIC STAFF

Lyle M. Allis, M.D. Robert J. Bahra, M.D. Dean P. Carron, M.D.

James R. Driver, M.D. Stuart M. Gould, Jr., M.D. Leonard E. Himler, M.D.* Francis M. Daignault, M.D. Sydney Joseph, M.D. Gordon C. Dieterich, M.D. Jacob J. Miller, M.D.

Rudolf Nobel, M.D. Richard D. Watkins, M.D. Hubert Miller, M.D. Robert L. Fransway, M.D. Gerard M. Schmit, M.D.

* 1904 - 1967

MATERNAL HEALTH DESK REFERENCE CARD NO. 12

(Sponsored and Prepared by the Committee on Maternal and Perinatal Health, Michigan State Medical Society)

The Management of the Non-sensitized Rh Negative Patient

(Supplement to Card No. 9 "The Management of the Rh- Sensitized Patient")

ANTEPARTUM

- I. All maternity patients should have an Rh determination as part of their initial laboratory studies.
- II. All Rh negative patients should have an antibody screen for atypical antibodies in the first trimester.
- III. If the antibody screen is negative, it should be repeated at 26-28 weeks and 32-34 weeks.
- IV. If the antibody screen is positive, the antibody should be identified and titered.
- V. Patients with anti-Rh antibody should be evaluated with serial amniocentesis as outlined in Maternal Health Desk Reference Card No. 9.

INTRAPARTUM

- I. Prevention of Large Fetomaternal Transplacental Hemorrhages.
 - A. Passive management of the third stage of labor:
 - 1. Do not give oxytocin prior to delivery of placenta.
 - 2. Clamp the cord immediately after delivery, cut it, and then, allow the maternal end to bleed freely after collecting the cord blood specimen.
 - 3. Assist delivery of the placenta only after it has separated and descended into the lower uterine segment.
 - 4. Give oxytocin IM after the placenta has been completely removed.
 - B. Manual removal of the placenta should only be done if indicated by excessive bleeding or retention greater than 15 minutes.
- II. Prevention of Rh isoimmunization
 - A. Blood Studies to determine eligibility for Rh Immune Globulin, These laboratory studies should be done Routinely on All Rh negative women and their newborn infants.
 - 1. Maternal blood
 - a. Confirm ABO group
 - b. Confirm Rh type
 - . c. Antibody screen
 - 2. Cord Blood
 - a. ABO group
 - b. Rh type
 - c. Direct Coombs
 - B. Eligibility
 - 1. Term deliveries. If the above studies confirm that the mother is Rh negative and not sensitized, and the infant is Rh positive with a negative Coombs, the nurse or laboratory technician should notify the attending physician that his patient is eligible to receive Rh immune globulin. Un-

less the mother is very certain that this is her last pregnancy, all eligible women should routinely receive Rh immune globulin within 72 hours of delivery.

- 2. Premature deliveries. They should be handled the same as term deliveries. Fetomaternal hemorrhages are a very definite possibility especially with placental accidents and operative deliveries which are common in this group of patients.
- 3. Abortions. Although it is theoretically possible to become sensitized after an abortion, there is no specific proof that this occurs. So, it is not necessary to give Rh immune globulin to Rh negative mothers after spontaneous abortions. There is some evidence that fetalmaternal hemorrhages may occur after therapeutic abortions. So, if the father is Rh positive, the mother should receive Rh immune globulin within 72 hours of termination of the pregnancy.
- 4. During pregnancy. It is very rare to have a large enough fetomaternal hemorrhage to break through the immune barrier and cause a primary immune response. So it is not necessary to give Rh immune globulin to pregnant women.

C. Dose

- 1. The usual dose of human Rh immune globulin (RhoGAM) is 300 ug IM given within 72 hours of delivery.
- 2. On occasion, the dose should be increased to 600-900 ug of RhoGAM if there is clinical evidence of a large fetalmaternal hemorrhage (anemic newborn, unexplained stillborn, severe childbirth chills, manual removal of placenta, etc.); and this is substantiated by laboratory studies such as mixed field agglutination on the crossmatch, Asby differential agglutination test, etc.

D. Follow up

1. No specific follow up laboratory studies are necessary between pregnancies.

FUTURE PREGNANCIES

- I. Every future pregnancy that the Rh negative mother has should be followed in the very same way.
- II. The Rh negative mother, assuming she does not become sensitized, should receive human Rh immune globulin after each Rh positive pregnancy.

Prevention of Rh Isoimmunization Grand Rapids Study Robert D. Visscher, M.D. Harrison C. Visscher, M.D.



ANCILLARY SECTION

Health Test Clinics For State Employees At Capacity Pace

Health officials administering multiphasic health screening tests to state civil service employees have been working at capacity since establishing four clinics around the state.

John A. Cowan, M.D., medical director of the civil services health maintenance unit, reports that by early November 2,800 state employees had been given hearing, vision, heart and blood chemistry tests, chest X-rays and urinalyses at clinics in Detroit, Lansing, Kalamazoo and on a mobile unit.

The Lansing clinic was opened in July, the Kalamazoo clinic in late September and the Detroit and mobile clinics in mid-October.

Approximately 39,000 of the 44,000 state employees are eligible for the tests, which are intended to show how well the individual is and to act as a tool to uncover "hidden diseases." The individual is referred to his own physician if any abnormality is detected.

About one-third of all the state employees undergoing the tests show a screen abnormality in some way, reports Doctor Cowan. He and his testing team have been surprised at the number of people who have hearing defects and don't know it and at the amount of cardio-vascular disease that has turned up in all ages — from 18 to the retirement ages of 65 and 70.

Christmas Seal Campaign Underway

The annual Christmas Seal campaign is underway in Michigan and across the nation.

During November and December, through the mails and the media, a network of volunteers across the state is promoting Christmas Seal contributions, which aid in the fight against tuberculosis and other respiratory diseases. The volunteers' goal is \$1,750,000.

Though the general public associates the campaign with the Yule season, Michigan TB and Respiratory Disease Association officers point out that Christmas Seal funds work all year.

New TB cases in 1968 in Michigan totaled 2,618, down from 2,951 new cases reported in 1967. Deaths due to TB in 1968 reached 262. It is estimated one in eight Michigan citizens harbors the TB germ. Deaths attributed to emphysema numbered 1,134 in 1968, up from the 1,049 registered in 1967.

It is such information the TB and Respiratory Disease Association hopes to make known using the funds raised by the Christmas Seal campaign.

Suggested Reading: MARMP Report, Pages 1261-1264

The Michigan Association for Regional Medical Programs has provided copies of its current Annual Report for inserting in this issue of Michigan Medicine, rather than mailing them separately to each physician. Insights into the goals and projects of MARMP can be obtained by reading the Annual Report, beginning on Page 1261.

FIRST FAMILY PRACTICE EXAMS FEB. 28-MARCH 1

The American Board of Family Practice announces that it will give its first examination for certification in various centers throughout the United States Feb. 28-March 1, 1970.

Information regarding the examination and eligibility for the examination can be obtained by writing Nicholas J. Pisacano, M.D., secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex No. 2 Room, 229, Lexington, Ky. 40506.

IN MEMORIAM

William D. Bennett, M.D. Pontiac

William D. Bennett, M.D., Pontiac psychiatrist for 14 years, died Nov. 2 at the age of 51.

Doctor Bennett, a graduate of the University of Michigan Medical School, practiced psychiatry at Utica State Hospital from 1947 to 1955 and opened a private psychiatric practice in Pontiac in 1955. He had been with the Pontiac State Hospital since 1966.

Burton R. Corbus, M.D. Grand Rapids

Burton R. Corbus, M.D., Grand Rapids physician who was president of the Michigan State Medical Society in 1940, died Oct. 23 at the age of 93.

Doctor Corbus had served on the MSMS Joint Committee on Health Education and was president of the Kent County Medical Society in 1912. During his tenure as state medical society president, Blue Cross and Blue Shield were established.

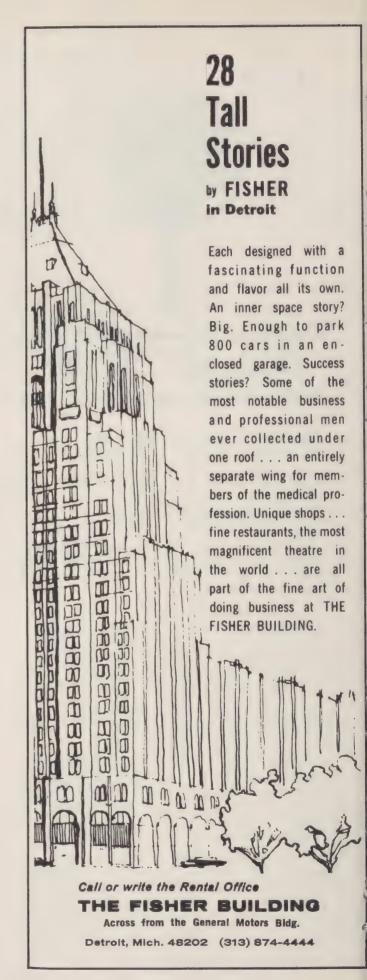
A graduate of the University of Illinois School of Medicine, Doctor Corbus had been medical director of the Alma Springs, W. Va., Sanitarium, and chief of medicine and chief of staff of Grand Rapid's Butterworth Hospital. He was a cofounder of the Michigan Foundation for Medical Health and Education.

Russell T. Costello, M.D. Detroit

Russell Thomas Costello, M.D., Detroit psychiatrist, died Oct. 12 at the age of 63.

Doctor Costello, a graduate of the Wayne State University College of Medicine, was affiliated with Harper and Providence Hospitals in Detroit. He was a member of the Central Neuropsychiatric Association, American Psychiatric Association, Academy of Neurology and the Society for Biological Psychiatry.

Doctor Costello was a professor of neurology at Wayne State University.



1306 MICHIGAN MEDICINE DECEMBER 1969



A good way to treat patients and save them money.

LEDERCILLIN® VK

Potassium Phenoxymethyl Penicillin

in tablets and a good-tasting, wild cherry liquid.

Tablets: 250 mg

Oral Solution:

125 mg/5 cc-80 cc and 150 cc 250 mg/5 cc-80 cc and 150 cc

Contraindications: Previous hypersensitivity to penicillin.

Warning: Serious, occasionally fatal, anaphylactoid reactions have been reported; more likely with sensitivity to multiple allergens. Some with penicillin hypersensitivity have had severe reactions to cephalosporin; inquire about penicillin, cephalosporin, or other allergies before treatment.

Precautions: Use with caution in those with his-

tories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm or intestinal hypermotility. Occasional patients will not absorb therapeutic oral amounts. In streptococcal infections, treat until organism is eliminated (10 days minimum) and demonstrate elimination by follow-up culture. With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, black hairy tongue. Skin eruptions, urticaria, serum-sickness reactions, laryngeal edema, fever, eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, nephropathy, usually at high parenteral dosage.

LEDERLE LABORATORIES
A Division of American Gyanamid
Company, Pearl River, New York

510-9

Arthur R. Ernst, M.D. Arlington, Va.

Arthur R. Ernst, M.D., of Arlington, Va., who was a Saginaw physician for 37 years, died Sept. 15 at the age of 84.

Doctor Ernst was a former president of the Saginaw Medical Society and was successively chief of obstetrics, chief of staff and chief of surgical staff of St. Mary's Hospital, Saginaw.

Doctor Ernst was graduated from the University of Michigan Medical School and practiced from 1913 to 1950 in Saginaw. He was a member of the American College of Surgeons and was a registered pharmacist.

Brenton M. Hamil, M.D. Dearborn

Brenton M. Hamil, M.D., Dearborn pediatrician, died Oct. 6 at the age of 71.

Doctor Hamil, a graduate of the State University of Iowa College of Medicine, was affiliated with Henry Ford Hospital since 1936 and had formerly served on the staffs of Harper Hospital, Children's Hospital of Michigan, Providence Hospital and Sigma Gamma Hospital School.

Doctor Hamil was a former Delegate from the Wayne County Medical Society to the MSMS House of Delegates and served as president of the Detroit Pediatric Society.

He was a member of the American Academy of Pediatrics, the American Diabetes Association and the Detroit Physiological Society, as well as numerous civic groups, including the Detroit Commission on Children and Youth, the Wayne County Conference of Physicians and Schools, and the Michigan unit of the 1960 White House Conference for Children and Youth. He was also on the faculty of the Wayne State University School of Medicine.

Harold J. Kitto, M.D. Flint

Harold J. Kitto, M.D., Flint pediatrician, died Sept. 29 at the age of 43.

Doctor Kitto was a graduate of the University of Michigan Medical School and was affiliated with Hurley, McLaren and St. Joseph's Hospitals in Flint. He was formerly on the staff of the Mott Children's Health Center and went into full-time private practice in 1958.

He devoted much time to developing diagnostic methods for cystic fibrosis patients and was a diplomate of the American Academy of Pediatrics, and a member of the American Board of Pediatrics, In 1954 he received the Borden Undergraduate Research Award for outstanding research in physiology. He was active in the Flint Community Planned Parenthood Association.

James A. MacDonell, M.D. Grand Rapids

James A. MacDonell, M.D., Grand Rapids orthopedic surgeon for 18 years, died Oct. 26 at the age of 57.

Doctor MacDonell was immediate past president of the Michigan Orthopedic Society and chief of staff at Mary Freed Bed Hospital and Rehabilitation Complex, Grand Rapids. He was also consulting surgeon at St. Mary's, Butterworth, Ferguson-Droste-Ferguson and Blodgett Memorial Hospitals in Grand Rapids.

Doctor MacDonell was graduated from the Stritch School of Medicine at Loyola University, Chicago and had practiced in Grand Rapids since 1951. He was a member of the American Academy of Orthopaedic Surgery and the Clinical Orthopaedic Society.

Burton L. Schmier, M.D. Plymouth

Burton L. Schmier, M.D., of Plymouth, a member of the staff of Wayne County General Hospital, died Oct. 10 at the age of 63.

Doctor Schmier was a graduate of the University of Michigan Medical School and was a member of the National Board of Psychiatrists. He was a native of Detroit.



For Your Library

Copies of "A Century of Service in Medicine," published as a Centennial highlight by MSMS, are still available for cost, \$2.00. The book, bound handsomely in blue, was written by Wm. J. Stapleton, Jr., M.D., of Detroit, the MSMS Historian. To obtain a copy, write to MSMS, 120 West Saginaw, East Lansing, and enclose a check.

"coughing
is not a harmless
privilege".

Current Therapy 1967, ed. by Conn, H. F., P. 88—

if cough serves no useful purpose

Rx Tussionex®

usually
for 10 to 12
hours*)

TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.

Class B narcotic - oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

*DOSAGE: Adults: 1 teaspoonful (5 cc.) or tablet every 8-12 hours. Children: Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N. Y. 14623

neart tells him he's an invalid

A little may even be desirable. Anxiety is expected in the cardiovascular patient.

interferes with sleep ... when it aggravates But when anxiety is exaggerated ... when it cardiovascular symptoms, your help may be needed.

Naturally, you'll want to reassure the patient.

as adjunctive therapy. It helps relieve anxiety and tension specifically, yet gently. And perhaps prescribe Equanil (meprobamate)

drowsiness; serious, therapy-interrupting is usually well tolerated as well as effective. Side effects are generally limited to transient side effects are rare. Almost 15 years' use has shown that Equani

Contraindications: History of sensitivity to meprobamate

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

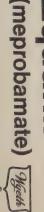
Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopabular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include anglioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis,

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern, impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, ancrexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended. stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.











Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate.

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.



WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals

Classified Advertising

\$5.00 per insertion of 50 words or less, with an additional 10 cents per word in excess of 50.

- PRACTICE OPPORTUNITY Active General practice in progressing community 30 miles north of Detroit. Modern office, fully equipped and staffed. Present gross over \$70,000 in four day week. Will introduce M.D. or D.O. Priced for immediate sale or lease. Reply Box #10, 120 W. Saginaw Street, East Lansing, Michigan.
- IMMEDIATE VACANCIES FOR SPECIALISTS OR G.P.'S in medical department of a large institution for the mentally retarded. Institution includes a large patient residential area, a pediatric building accommodating some 200 children, a 100 bed infirmary, a 200 bed general hospital with medical, surgical and selective surgery wards, an active O.R., well equipped diagnostic facilities; clinical and genetic research laboratories, X-ray Dept., P.T. Dept., etc. Annual Salary ranges from \$20,000 to \$27,000 depending on qualifications. Michigan licensure, or ECMFG for foreign graduates is required. Contact: Isak O. Berker, M.D., Medical Director, Lapeer State Home and Training School, Lapeer, Michigan 48446.
- DOCTORS! Monroe, Michigan, City of 30,000 County of 100,000. Located Lake Erie near Toledo, Detroit. Excellent schools, community college, 300 beds in two new hospitals. Openings for General, ENT, Urology, Orthopedic Surgery. Contact: R. W. Wilkins, M.D., Secretary Monroe County Medical Society, 118 Cole Road, Monroe, Michigan 48161
- OBSTETRICIAN-GYNECOLOGIST and Internist needed by a seven man group in Northeastern Wisconsin, adjacent to the Upper Peninsula. Full details on this excellent opportunity may be obtained by writing James Boren, M.D., 1510 Main Street, Marineute, Wisconsin 54143.
- OBSTETRICIAN-GYNECOLOGIST to associate with young certified O.B. Brand new hospital. Michigan Thumb recreation area. \$22,000 first year, then full partnership. James M. Mullaney, M.D., 206 N. Heisterman, Bad Axe, Michigan 48413 (517) 269-7409.
- DOWNSTATE ILLINOIS progressive community 42,000 population; Universities of Illinois, Indiana, and Purdue nearby; good schools including Junior College adjacent to hospital; new, well equipped General Medical and Surgical Hospital; interested in all specialties as well as GP; away from busy metropolitan traffic; 120 miles south of Chicago, 85 miles west of Indianapolis via I-74; beautiful 9-hole championship golf course on grounds; an equal opportunity employer; salary \$15,812 through \$28,069 based on training and experience. Licensure in one state is required for appointment. Write to: Chief of Staff, David P. Morton, M.D., Veterans Administration Hospital, Danville, Illinois 61832 (Area Code 217, Telephone Number 442-8000 Ext. 353).

- OUTSTANDING FAMILY PRACTICE in Michigan's Thumb. Completely equipped two man clinic, grossing over \$200,000 yearly. New 2½ million dollar hospital nine miles away. Excellent schools and recreational facilities. Contact Box #13, 120 West Saginaw St., East Lansing, Michigan 48823.
- WANTED: General Practitioner for private and industrial practice Suburban Detroit, full or part-time. Terms open. Michigan license required. Reply Box 162, Madison Heights, Michigan 48071.
- WANTED: Younger general surgeon-GP for opening in busy established practice in town of 3500 in N.E. Minn. Salary \$45,000 first year, then partnership. T. C. Leach, M.D., Babbitt Clinic, Babbitt, Minnesota 55706
- NEW EXPANDING OPPORTUNITIES for family physicians and physicians specializing in pediatrics, general surgery, internal medicine, urology, radiology, anesthesiology; in medically-awakening community. Contemporary, automated, 105-bed, new hospital to be completed in the fall of 1970. Present hospital to be converted into long-term unit. Patient service area 50,000 people. Medical staff leading and supporting recruitment efforts. Excellent community location, forty miles equidistant to Milwaukee or Madison. Complete educational, cultural and recreational facilities. Possibility of new medical office building adjacent to new hospital. Immediate satisfaction in practice, income and family living. Special assistance if needed. Write or call Leo C. Bargielski, Administrator, Watertown Memorial Hospital, 1301 E. Main Street, Watertown, Wisconsin, 53094; telephone (414) 261-4210 for more information.
- INTERNAL MEDICINE practice for sale: will introduce; Florida license required. P.O. Box 4481 Miami Beach, Florida 33141.
- EXTREMELY BUSY two man group needs OB man, who is willing to do some general practice, or a GP who particularly wants to do OB. New modern 80 bed hospital with CCU unit. Small town in northern Michigan, serving an area of about 12,000 people. Office space available, and financial arrangements entirely open to discussion. P.C. possible. Write Box 12, 120 West Saginaw, East Lansing, Michigan 48823, or phone (517) 846-6122.
- INTERNIST: Board certified or eligible. 233 bed hospital in Michigan's vacationland. All seasons sports resort area, skiing, hunting, fishing. Licensure any state. Salary based on qualifications. Excellent fringe benefits. Non-discrimination in employment. Contact, Chief of Staff, VA Hospital, Iron Mountain, Michigan 49801.

- GENERAL SURGEON, age 44, board certified, experienced, intends to relocate July 1970. Consider any location in Michigan, solo practice or association. Reply Box 11, 120 West Saginaw Street, East Lansing, Michigan 48823.
- FOR SALE or Lease: Due to recent death of internist, office for one or two physicians available at once. Growing industrial area in need of internists and GP's. Office five blocks from hospital. New hospital to be completed in 1970. Nurse will stay six months. For further information, contact: Mrs. Harold R. Weidner, 16 S. Fremont Street, Coldwater, Michigan 49036.
- 46 YEAR OLD, certified general surgeon seeking partnership or association with group. Available January 1970. Write Box #14, 120 West Saginaw Street, East Lansing, Michigan 48823.
- PSYCHIATRIST, SURGEON, GENERAL PRACTITIONER. 1518 bed predominantly psychiatric VA Hospital, located in East Central Indiana. Special programs in psychiatric and geriatric rehabilitation; alcoholic treatment unit. Active medical and surgical services. Family rental units at reasonable rates usually available on hospital grounds. 30 days of leave annually; retirement; health, life insurance plans without physical examination; and other benefits. Can pay moving expenses. Salary depending on qualifications. License any State required. Equal opportunity employer. Contact: Chief of Staff, VA Hospital, Marion, Indiana 46952 or call (317) 674-3321, Ext. 233.
- PHYSICIAN (Full or part-time) for Staff position in a 200 bed modern, progressive general hospital in beautiful residential community. Salary dependent upon qualifications, ranging from \$19,767 to \$25,189. Excellent fringe benefits. Must be licensed to practice in a State, Territory, or Commonwealth of the United States or in the District of Columbia. Non-discrimination in employment. Contact Hospital Director, Veterans Administration Hospital, Fort Wayne, Indiana.
- PHYSICIAN to be responsible for medical aspects of laboratory program, including research and developmental problems and clinical trials of biologic products in a large public health laboratory having broad resources in diagnostic microbiology and biologic products production. M.P.H. training or experience in epidemiology, biostatistics, and design and execution of clinical trials desirable. Must have or be eligible for a license to practice in Michigan. Salary range: \$23,510 to \$29,023, depending on experience. Excellent fringe benefit program. Apply to Kenneth R. Wilcox, Jr., M.D., Dr. P.H. Associate Director for Laboratory Services, Chief, Bureau of Laboratories, Michigan Department of Public Health, 3500 North Logan Street, Lansing, Michigan 48913. An equal opportunity employer.
- FOR LEASE: In attractive Medical Building, four offices available for single or combined occupancy (Total 4000 sq. ft.). Will design to suit. Located in

- fastest growing area in suburban Grand Rapids. Easy access to all parts of the city. Abundant parking. Opportunity to live in lovely metropolitan area close to Michigan's finest fishing, hunting, sailing and skiing. Ready for occupancy in November. Phone: 1-616-363-3822 or 1-616-361-9387.
- DOCTORS Munising, Michigan, has a drawing area of 10,000 people with its excellent schools, best water sports, and hunting in the Great Lakes and a 35 bed modern hospital with an ICCU, physical therapy, inhalation therapy, and surgery. There is an opening for a general surgeon or general practitioner who would like to do some general practice and surgery and work with a young general practitioner. The offices are located next to the hospital. If interested, contact Neil Grossnickle, M.D., Sand Point Road, Munising, Michigan 49862.
- PARTNER WANTED so as to furnish better coverage, Family practice. AAGP member. Age 54 established for some years, good location, Livonia mostly Medical & Pediatrics. Phone (313) 474-3650 days or come to 19075 Middlebelt Road, Livonia, Michigan 48152.
- WANTED: House Physician, Days, 10:00 a.m. to 6:00 p.m., Monday through Friday, no weekends or holidays. Ten patients per average day. Salary \$25,000 per year, plus fringe benefits. Please call or write: Mr. Richard S. Hiltz, Administrator, Memorial Hospital, Monroe, Michigan 48161.
- ANN ARBOR-YPSILANTI AREA. Three year AMA approved, university affiliated psych. residency offering comprehensive MH services to SE Michigan. Teaching faculty and supervisors include U. of M. faculty, private psychiatrists and analysts, as well as hospital staff. Resident's time divided approx. equally between didactic seminars (including supervision) and clinical experience. First year ADM & Intensive Treatment units; second and third year assigned Community Psych. and/or OPC and/or Children's Unit. Additional experience in psychosomatic medicine, Univ. Mental Hygiene Clinic, and neurology. 3-year: \$10,669 to \$12,131. 5-year: \$12,152 to \$21,944. \$15,000 NIMH grants available eligible physicians in practice 4+ years. Contact: J. Tiziani, M.D., Ypsilanti State Hospital, Ypsilanti, Michigan 48197.
- LARGE COMMUNITY HOSPITAL and Medical Center in the southwest need a full time director of Internal Medicine service. Hospital has over 500 beds, internships and eight approved residency programs including internal medicine. Member of the Council of teaching Hospitals of AAMC. Director of Internal Medicine is responsible for all activities related to Internal Medicine within the medical center. Annual Compensation \$40,000. Reply: Box 15, 120 West Saginaw Street, East Lansing, Michigan 48823.
- WANTED: G.P. Locum tenens. Summer 1970, 1 to 6 weeks, mid July to Sept. Stipend \$500.00 per week plus commission. Must have Michigan license and furnish two references. Reply: Box 16, 120 W. Saginaw Street, East Lansing, Michigan 48823.

Index to Advertisers They Help Make Michigan Medicine Possible

Arch Laboratories1315	Medical Protective Co1302
Arnar-Stone Laboratories, Inc1228	Mercywood Hospital1302
Brown Pharmaceuticals1293	Parke-Davis & Co
Burroughs Wellcome & Co1252	Pfizer Laboratories1290, 1291
Campbell Soup Co	Plainwell Sanitarium1299
Classified Ads	Poythress, Wm. P
Fisher Bldg., The1306	Robins, A. H. & Co 1258, 1281, 1282, 1283
Glenbrook Laboratories (Bayer)1287	Roche Laboratories1249, 1250, 1251, 1288,
Henry Ford Hospital1253	1289, Cover IV
Hynson, Westcott & DunningCover III	Sandoz Pharmaceuticals1298
Ingram Company, G. A1259, 1293	Searle, G. D. & Co
Lederle Laboratories 1226, 1296, 1297,	Smith, Kline & French Laboratories1260
1307, 1315	Strasenburgh Laboratories
Lilly, Eli & Co	Stratton, Ben PCover II
Mead Johnson Laboratories1278, 1279,	Stuart Co., The
1300, 1301	Wyeth Laboratories 1254, 1255, 1310, 1311

Efficficlency

Dicarbosil
ANTACID

Your ulcer patients and others will confirmit. Specify DICARBOSIL 144's—144 tablets in 12 rolls.

ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102



In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

LEDERLE LABORATORIES

A Division of American Cyanamid Company, Pearl River, N.Y.

QQNOTES & QUOTES 99

BY HERB AUER, EXECUTIVE EDITOR

"The doctor of medicine must accept his leadership role in helping his community understand that school and church must play their part in sex education programs by supplementing the parental effort," so writes Mary S. Calderone, MD, Director of SIE-CUS, in a recent issue of the Journal of the Medical Society of New Jersey. She points out that, "Profound changes in society cannot be resisted by going back to the horse-and-buggy methods. We must enlist ourselves with our young people to try to help them with the job of living personally and with fulfillment and responsibility in a computerized, depersonalized world of startling knowledge accumulation."

One of medicine's best sellers continues to be the popular Today's Health Guide, the AMA's book of what every family and child should know about sound health habits, preventive care, and the "mechanisms" of the human body.

The revised edition of the book has already had a sales figure of 65,905.

An insurance company study of Americans' eating habits and weight patterns over the past 20 years found that adults are tending to stay away from rich, fattening desserts. Are they slimmer as a result? That depends on their sex, according to an item in a recent National PTA Magazine. The average woman today is eight pounds lighter at the age of 35 than the average woman of the same age in 1949. Men in their 40's on the other hand, weigh an average of five pounds more than their counterparts two decades ago.

A warning that the private practice of medicine as we know it may die unless drastic actions are taken is voiced by Robert S. Long, MD, Omaha, former president of the American Society of Internal Medicine. He calls on medical teachers to "exert greater efforts to orient suitable students toward private practice and practical patient care. . . Unless we do, it will not be long before there are no more private practitioners. Everyone will be in a salaried hospital, medical school, governmental or administrative position."

Admirers of Morris Fishbein, MD, former editor of JAMA and editor now of Medical World News, will be interested in reading Morris Fishbein, MD, an Autobiography published recently by Doubleday. Doctor Fishbein tells many interesting anecdotes in describing his work with the AMA where he served under almost 40 different administrations — an unparalleled feat.

The move away from smoking by children of professional people is really the only dramatic change in the Surgeon General's Report for 1968 as contrasted to the 1964 report. The number of variables relating to smoking habits and attitudes did not differ significantly in most aspects of the two studies. Salvatore V. Zagona, Director of the University of Arizona Center for Research on Smoking and Health, contends that "the failure of anti-smoking programs is caused primarily by the fact that other stronger social pressures exist that neutralize them." Professor Zagona points to the many television programs on which "vigorous, successful entertainers puff cigarette smoke toward the cameras.'

A recent issue of the Journal of the Florida Medical Association provides some interesting food for thought. An editorial, by I. Leo Fishbein, MD, of Miami Beach, discusses "Seven Pillars of Sanity." He erects such constructive pillars as Wisdom, Compassion, Understanding, Forgiveness, Simplicity, Patience and Humor.

Hideya Kumata, a research authority on communications at MSU, offers the following startling statistics:

TV: Adults spend 35 hours per week watching television.

RADIO: The average person spends 12 hours a week listening to radio.

NEWSPAPERS: 95% of American adults read one or more newspapers daily but they only spend 20 minutes a day or $2\frac{1}{2}$ hours a week doing so.

MAGAZINES: A dults spend 2 hours per week reading magazines.

BOOKS: 72% of Americans read less than 1 book a year; one-half billion paperbacks are published annually. Ten percent of the population accounts for 90% of these purchases.

Magazines and newspapers tell about the great plans that Minoru Yamasaki, architect for the MSMS headquarters, has for the World Trade Center in New York City, but the articles often fail to list the many other challenging projects he has underway. In addition to the World Trade Center (two 110-story towers on a 17 acre site at a total cost of \$600 million) Yamasaki's current work includes three 10-story Defense Department office buildings in Washington, a 42-story tower to house offices of Century City in Los Angeles, hotels in Singapore and Tokyo, etc. His Michigan projects include a styling center for Chrysler in Highland Park and a synagogue for Temple Bethel at Telegraph and Fourteen Mile in Bloomfield Townships.



HW&D BRAND OF LUTUTRIN 3000 UNIT TABLETS

IN THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF PREMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

■ LUTREXIN, the non-steroid "uterine relaxing factor" has been found to be useful by many clinicians in controlling abnormal uterine activity.

Literature on indications and dosage available on request.

- No side effects have been reported, even when massive doses (25 tablets per day) were administered.
- Supplied in bottles of twenty-five 3,000 unit tablets.



(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

East Lansing, Michigan 48823

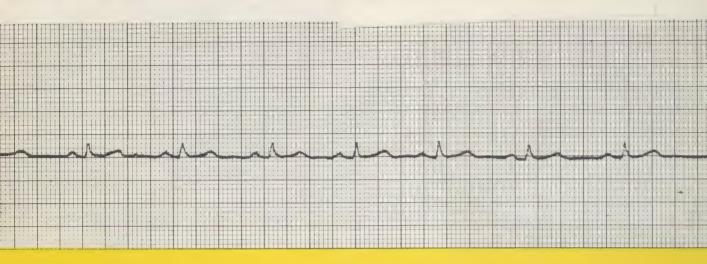
120 W. Saginaw

MICHIGAN STATE MEDICAL SOCIETY

NATL LIBRARY OF MED 8600 WISCONSIN AVE

BETHESDA MD

20014



When disease is ruled out and psychic tension is implicated

Valium[®] (diazepam)

helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation

or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

DECEMBER 1969 • VOLUME 68 • NUMBER 25

MSMS Sponsors Rose Bowl Trip; See Page 1319

Of Michigan Department of Public Health



Doctor Rice

R. Gerald Rice, M.D., East Lansing, has asked that he be relieved of his duties on March 30, 1970, as director of the Michigan Department of Public Health, due to ill health. Gov. William Milliken accepted Doctor Rice's resignation Nov. 28 with "deep regret."

Doctor Rice was appointed to the \$32,000-a-year post in October of 1968, but told Gov. Milliken in a letter, "I have not been well and have been unable to perform in this position as I feel I should perform." He sought retirement by March 30 "or at any time previous to that which is convenient" to the governor.

Doctor Rice said he hoped to remain with the department in the field of child health.

Gov. Milliken responded to Doctor Rice in a letter: "Your leadership and dedicated service to the state and its residents in attempting to provide the quality and quantity of public health services necessary to make Michigan a health model are greatly appreciated by all of us."

Doctor Rice, who is 55, was appointed director of the Michigan Crippled Children Commission in 1964 and became chief of the Bureau of Maternal and Child Health and associate director for Maternal and Child Health in 1966. He served as acting director of the Michigan Department of Public Health in 1967-68.

Doctor Rice previously headed the Massachusetts and the Pennsylvania maternal and child health divisions for eight years each.

Gov. Milliken noted that during Doctor Rice's tenure as director,

the Michigan Department of Public Health initiated or expanded \$8 million worth of new programs and services for Michigan residents.

Doctor Rice is a member of the Association of State Maternal and Child Health and Crippled Children Directors and is a fellow of the American Public Health Association.

He received his M.D. degree from McGill University, Montreal, and his M.P.H. degree from Harvard University.

FDA Warns of Catheter Kits

Michigan physicians are warned by the Detroit office of the FDA against the dangers involved in the use of 49 types of urethral catheter trays and kits produced by the C. R. Bard, Inc., because of the possibility of serious infection.

The FDA declares that, "All of these trays contain a packet of cleansing solution or 'detergicide' (also called 'prep solution,' 'cleansing solution,' or 'antiseptic towlette') which has been found to contain bacteria of pseudomonas species, commonly known as EO-1, a pathogenic organism which may produce severe genito-urinary infections."

The FDA urges physicians and nurses and officials of hospitals and

nursing homes to take immediate steps to check all stocks of sterile urethral catheter trays or kits from Bard and arrange for their prompt return to the supplier of any existing stocks bearing any of the re-order or item numbers listed below:

7501 7503 7505 7602 7602P 7604 7610 8145 8214 8216 8218	8300 8364-16 8364-18 8365-16 8365-18 8400 8401 8464-16 8464-16 *8464-D-16	8465-18 8500 8501 8504-16 8505-16 8505-18 8505A-16 8505A-18 8554-A 8554-A	8560-A 8560 8810 8816 8816-A 8818 8818-A 8819 4200 4210
8218 8220	*8464D-18 8465-16	8556 8556-A	4210

^{*} Labeled as Bardex Pak, Daval Rubber Company.

WSU Symposium On Blood Set Jan. 16-17

"Platelet Adhesion and Aggregation in Thrombosis: Countermeasures" is the theme of the 18th Annual Wayne State University Symposium on Blood scheduled from 9 a.m. to 5 p.m. Jan. 16-17 at the McGregor Memorial Conference Center at WSU.

Symposium Chairman Eberhard F. Mammen, M.D., Detroit, has secured 31 speakers for the two-day event, nine of them from the overseas countries of Sweden, Norway, Germany and England.

The first day of discussion will be devoted to the physiological, biochemical and electrochemical aspects of the adhesion of platelets in the blood, while the second day's talks will center on the pharmacological substances that prevent platelet aggregation.

"At the present we only treat, and do not prevent thrombosis," says Doctor Mammen. "In the last five years we have learned that platelet aggregation is one of the early phases of blood clotting and if we can ever find drugs to inhibit this early phase then we will be much better able to prevent thrombosis."

Major speakers will include Marjery B. Zucker, M.D., New York, who will give the "Introduction to Platelet Adhesion and Aggregation"; R. Gross, M.D., professor of internal medicine and chairman of the Department of Medicine, the University of Cologne, Germany, who will discuss the "Clinical and Experimental Aspects of Aggregation Inhibitors"; T. Hovig, M.D., of Oslo, Norway, "The Role of Platelets in Thrombrosis," and H. Gastpar, M.D., the University of Munich, Germany, "Stickiness of Platelets and Tumor Cells Influenced by Drugs."

Be Sure to Save New 1969-70 MSMS Directory

The new Directory of MSMS Members recently was mailed to all members.

Members are urged to save it for reference purposes.

The names and addresses of the county society membership lists are accurate as of Oct. 1, 1969. The other reference-type lists are accurate as of Nov. 1, 1969.

The 1969 MSMS House of Delegates took formal action that the membership directory should no longer be published each winter, but be issued every other year. Lists of new members and their addresses will be printed regularly in *Michigan Medicine*, and other revised information will be provided there so members may add to this directory.

The next Directory will be published about December, 1971.

Any member finding an error in his name or address is requested to notify MSMS so the records can be corrected. Contact The Membership Department, MSMS, 120 West Saginaw, East Lansing, Michigan 48823.

Umbrella Liability Insurance Being Readied for MSMS Members

The Employers-Commercial Union Group Insurance Company hopes to have its umbrella excess policy of liability insurance on the market for MSMS members in January. Final preparations are now being made for a formal announcement.

"We certainly will make every effort to have the policy available in January — that's our deadline," commented Ben Stratton of Lansing, MSMS insurance counsel. Mr. Stratton is acting as agent for MSMS in drawing up the policy with the Employers-Commercial Union Company.

At its November meeting, the MSMS Council approved a proposal for the policy, which was offered at that time by the Employers-Commercial Union Company, subject to approval by the insurance commissioner. Mr. Stratton had recommended the company.

Under the policy the insurance company would pay in excess above required basic underlying coverage. This contract would apply to legal liability developing out of any circumstances. The physician thereby would have protection supplementing not only his basic professional liability insurance, but his auto liability, homeowner's liability and boat owner's liability as well. In the event he possessed no primary protection against a particular situation of liability, the insurer under the umbrella excess policy would assume his responsibilities beyond a deductible.



RESOLUTION PASSED AT DEC. 12 MEETING

MSU Negotiating With DO School

The Michigan State University Board of Trustees is negotiating with the Michigan College of Osteopathic Medicine (MCOM) at Pontiac with respect to establishing an osteopathic college at MSU.

The action follows the MSU Board's Dec. 12 adoption of a resolution expressing its willingness to negotiate with MCOM, the next step toward development of a state-supported osteopathic school at MSU. The MSU board has until Jan. 1 to accept the assignment of the DO school by the State Board of Education.

The MSU trustees had delayed their decision a month when the MSU Academic Council requested that the faculty be consulted before acceptance. Richard U. Byerrum, Dean of the College of Natural Science, was chairman of a committee to sound out thoughts of the faculty about establishment of the state-supported college of osteopathy at MSU.

The committee discovered in talking with the faculty, Dean Byerrum said, that its chief concerns were that other programs at MSU not suffer financially in favor of the new college; that possible duplication of courses be checked; that regular university channels be used for selecting faculty and administrators for the new college, and that "there is a need for open inquiry, without prejudgement, of any aspect of osteopathy."

SCREEN TEST HIGHLIGHTED GENESEE DIABETES WEEK

One of the highlights of the Genesee County Medical Society Diabetes Week efforts was a cooperative screening-test project at Flint General Hospital. The hospital officials, explains John B. Rowe, M.D., Genesee Diabetes Detection Committee chairman, urged all physicians to encourage their patients to take advantage of the testing program in the hospital conference room that special week.

DEAN HUNT ELECTED

Andrew D. Hunt, Jr., M.D., East Lansing, has been elected a member-at-large of the Michigan Welfare League. Doctor Hunt is dean of the College of Human Medicine at Michigan State University.

STATE BAR DIRECTOR TO RETIRE DEC. 31

Milton E. Bachmann, executive director of the State Bar of Michigan for 23 years, plans to retire Dec. 31. Mr. Bachmann, of East Lansing, is also editor-in-chief of the Michigan State Bar Journal for the 11,000-member Bar.

Hearings Set On Rate Increases By 'The Blues'

The Michigan Insurance Commission plans a public hearing Dec. 23 at Lansing on proposed base rate increases by Michigan Blue Cross and Michigan Blue Shield for the second quarter of 1970.

Blue Cross is asking an average base rate increase of 2.4 per cent. Blue Shield is asking for an average base rate increase of 5.9 per cent. Both are asking for an increase averaging 10 per cent for senior citizen contracts.

In late October, the insurance commission approved a rate increase averaging 16.7 per cent to Blue Shield for its variable fee health insurance. The rate hike will be effective for the first quarter of 1970.

Russell E. Van Hooser, state insurance commissioner, said since any increase by the two groups would have a significant impact on a large percentage of citizens in the state, detailed and careful consideration would be given to every facet of the proposed rate revision.



MSMS is offering its members roses, sunshine, football and good fellowship through the sponsorship of a group travel plan to the Rose Bowl.

The plan, approved by The Council at its Dec. 10 meeting, includes an eight-day jet tour to Las Vegas and Los Angeles, highlighted by attendance at the Rose Bowl Parade and the Rose Bowl Football Game.

The tour begins Dec. 28 with a jet flight from Detroit's Metropolitan Airport to Las Vegas. Accommodations will be at the Aladdin Hotel in Las Vegas through Monday evening. Tuesday morning, guests will fly to Los Angeles and transfer to either the Sheraton Universal or Hacienda International Hotels, for the balance of the tour.

Highlights of the tour, in addition to the Rose Bowl and Parade, include attendance at the Minsky's Follies, Opera House and the Lido de Paris shows in Las Vegas; and an all-day visit to Disneyland, optional New Year's Eve party with Lawrence Welk at the Palladium, a trip to the Universal Movie Studio and a free day to enjoy Southern California.

The tour ends with a flight Jan. 4 from Los Angeles to Detroit's Metropolitan Airport. Cost of the trip, including air fare and hotel accommodations, is \$399.00 plus \$16.00 tax and services for each person.

A mailing with full details is being made to each MSMS member.

Also at the Dec. 10 meeting, The Council approved group travel plans for tours to the Caribbean from May 28 to June 11, 1970, and to the Orient in October, immediately following the 1970 MSMS Annual Session.

MARMP Has Newly-Elected Officers; Board, At-Large Members Already Chosen

The Michigan Association for Regional Medical Programs has again elected Don Marshall, M.D., Kalamazoo, as its president. Doctor Marshall served during 1968-69, and was vice president the previous two years.

New vice president of the organization is John Gronvall, M.D., Ann Arbor, while Dorothy Carnegie, D.O., Lansing, is new secretary-treasurer.

New board members and six public-at-large members selected recently are Dorothy Carnegie, D.O., Lansing; Ethelene Crockett,

DOCTOR O'CONNOR ON FACULTY FOR SYMPOSIUM

Over 40 physicians primarily from southeast lower Michigan participated in the Seventeenth Annual Symposium on Trauma Dec. 3 and 4 at The Wayne County Medical Society Headquarters. Sponsors were the Michigan Committee of Trauma of the American College of Surgeons and the Wayne State University School of Medicine.

Among the speakers was Gerald A. O'Connor, M.D., clinical assistant professor of orthopedic surgery and athletic team physician at the University of Michigan and chairman of the MSMS Committee on Medical Aspects of Organized Athletics.

M.D., Detroit; John Gronvall, M.D., Ann Arbor; Don Marshall, M.D., Kalamazoo; R. Gerald Rice, M.D., East Lansing; Irwin Schatz, M.D., Detroit, and Ronald Yaw, Grand Rapids.

The six new public-at-large members are Lawrence Doss of Detroit, W. Anson Hedgecock, Jackson; Matthew Kinde, M.D., Battle Creek; Kenneth Shouldice, Ph.D., Sault Sainte Marie; Victor Zink, Detroit and Theodore Goldberg, Ph.D., Huntington Woods.

Four new Michigan health organizations were also elected to membership in the MARMP corporation. The organizations and their representatives are the Comprehensive State Health Planning Commission, William Anderson, M.D., Lansing; Michigan Diabetes Association, James Bryan, M.D., Royal Oak; Michigan TB and Respiratory Disease Association, Mrs. Ned Deming, Kalamazoo, and the Wolverine Medical Society, Ethelene Crockett, M.D., Detroit.

Also in recent action, the MARMP corporation members approved the Wayne State University project on "Continuing Education for Small Inner City Hospitals" for submission to the Federal Division of Regional Medical Programs. This project proposes to establish a continuing education program in three, small, inner city general hospitals. The program will be implemented by the hospital staffs with the technical assistance of WSU personnel.

Michigan's eight delegates and eight alternate delegates to the American Medical Association were all in attendance at the AMA Clinical Meeting at Denver, Nov. 30 to Dec. 3, where six of the 60 resolutions considered were introduced by Michigan. All six Michigan resolutions were adopted.

A review of the significant role played by the MSMS delegation will appear in the blue pages of the January issue of M!CHIGAN MEDICINE, states Donald N. Sweeny, Jr., M.D., Chairman of the delegation.

WAYNE PHYSICIANS' PAPER RECEIVES ACCP FIRST PRIZE

Two Wayne physicians who coauthored a medical paper on coronary artery deficiency cases were awarded a first prize by the American College of Chest Physicians recently. The paper described a method for delivering more blood to the heart.

The prize-winning physicians are John D. Watts, M.D., a resident at Detroit General Hospital, who received the money award of \$1,000 in the area of cardiovascular research; and his teacher, Augustin Arbulu, M.D., professor of surgery in the Wayne State University School of Medicine.

This is the second consecutive year that one of Doctor Arbulu's students has gained first prize among the writings and research of the 8,000 ACCP members.

Second Class Postage Paid at East Lansing, Mich. and at additional mailing offices.

Michigan Medicine

MICHIGAN STATE MEDICAL SOCIETY

Published semi-monthly, Trimonthly in November and December; 26 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, \$9.00. Printed in USA. All communications should be addressed to the Publications Communications should be addressed to the Publications Communitate, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. © 1969 Michigan State Medical Society. Phone: Area Code 517, 337-1351.

NLM-MX2 BOX Q BETHESDA MARYLAND

20014





